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REMOVAL OF A NUTRIENT FEEDING TUBE
AND THE NEED FOR A LIVING WILL

In a continuing effort to apply legal principles to the life and death questions presented by modern medical procedures, at least two state courts, New Jersey and Massachusetts, have recently wrestled with the question of whether to allow removal of a feeding tube from an incompetent patient. In New Jersey and Massachusetts, have recently wrestled with the question of whether to allow removal of a feeding tube from an incompetent patient. There are some who argue that removal of a feeding tube is a form of active euthanasia whereby the patient would starve to death. Others maintain that removal of a tube which mechanically provides nutrition and hydration is completely analogous to removal of an artificial respirator, a practice which was recognized as permissible in the seminal case involving Karen Ann Quinlan. In 1976 the Supreme Court of New Jersey announced in In re Quinlan that the right to refuse medical treatment can be extended to an incompetent patient by way of a third party guardian. The Quinlan court sanctioned a request for the removal of an artificial respirator, thought to have been sustaining Miss Quinlan's life. As a forerunner in this area, the New Jersey State Supreme Court has recently decided in In re Conroy that there is no analytical difference between removing an artificial feeding tube and disconnecting an artificial respirator. Similarly, in Brophy v. New England Sinai Hospital, the Supreme Judicial Court of Massachusetts has held that there is no difference between removal of an artificial respirator and denial of nutrition through the removal of a feeding tube.

In addition to the debate in state courts regarding the legality of removing nutrient feeding tubes, thirty-six state legislatures and the District of Colum-

2. See generally Horan & Grant, The Legal Aspects of Withdrawing Nourishment, 5 J. LEGAL MED. 595 (1984) (concluding that removal of any feeding tube would be the direct and proximate cause of death by starvation).
3. See Note, Natural Death: An Alternative in New Jersey, In Re Conroy, 73 GEO. L.J. 1331, 1339 (1985) (where the author suggests that the distinction between active and passive euthanasia is a nebulous one).
7. Brophy, No. 4152, slip op. at 32.
biases continue to grapple with the broader issue of the right to die by enacting living will statutes. These statutes, popularly referred to as Living Will, Natural Death or Right to Die Acts, provide a vehicle for individuals to assist themselves and others in this area of decision-making. The typical dilemma is a scenario whereby an individual has suffered irreversible brain damage and is in a persistent vegetative state. The question then becomes whether to maintain "life" through artificial means. These statutes are intended to relieve the families and physicians of the burden of such decisions by allowing individuals to make their own choice in advance and then to publish that decision in a living will declaration. Typically, the living will instructs the physician to remove life support systems when there is no hope for recovery. Some scholars have suggested that the living will is the best solution to the moral and legal controversies which surround the subject of euthanasia. Unfortunately, these living wills do not always provide the simple answer for which they were intended.

The thrust of this comment is twofold. It begins with a discussion of what standards may be applied by third parties in the decision-making process for


10. See generally Reaves, Willis: Uniform Law Proposal, 70 A.B.A. J. 29 (1984) (discussing the problem of enforceability of a living will executed in a foreign jurisdiction and the need for reciprocity among the states with these statutes. One of the problems, however, is that the state statutes vary so significantly that reciprocity would be difficult. Accordingly, the National Conference of Commissioners on Uniform State Laws ("NCCUSL") has taken up the issue of a uniform living will act.). See also Note, Living Wills — Need for Legal Recognition, 78 W. VA. L. REV. 370 (1976).
an incompetent patient, and how these standards meet the important need for certainty. In this discussion, a careful analysis is made of the substituted judgment test and how living wills may be an example of documenting the wishes of a patient so as to provide the needed certainty. Second, this comment presents an analysis of when these standards should apply and whether the incompetent patient’s death need be imminent before a third party guardian’s request may be considered. Here, the comment attempts to discern whether there is a true analytical difference between removal of an artificial respirator and removal of a nutrient feeding tube. Specifically, the question of whether a feeding tube can be classified as “extraordinary care” (so as to be removable) is addressed.

I. THE HISTORY OF THE RIGHT TO REFUSE MEDICAL TREATMENT

Although not explicitly mentioned in the Constitution, Mr. Justice Brandeis stated in a 1928 dissenting opinion regarding the notion of the right to privacy, that “[the makers of the Constitution] conferred against government the right to be left alone — the most comprehensive of rights and the right most valued by civilized men.”

It was not until the 1965 decision of Griswold v. Connecticut that the Court first clearly enunciated the concept of an unwritten penumbra right of privacy emanating from the Bill of Rights as a guarantee under the Constitution. This right has developed to include the right to marry, to have children and to receive contraceptives. Placing this privacy right in the context of decisions to decline medical treatment, the Court held in the landmark case of Roe v. Wade that a woman’s decision to terminate her pregnancy is protected under this right. Presumably, the federal right is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to

14. Carey v. Population Serv. Int’l, 431 U.S. 678, 685 (1977) (right of minors to receive contraceptives, where the Court held that the “decision whether or not to beget or bear a child” is encompassed by the “constitutionally protected right of privacy”).
encompass a woman’s decision to terminate pregnancy under certain conditions.

Although state courts have extended this right to the decisions regarding the discontinuation of life-sustaining medical treatment, the Supreme Court has not yet considered such a case. The federal constitutional right of privacy continues to be interpreted by several state courts to include a patient’s decision to decline medical treatment under certain circumstances, even where the decision may lead to the patient’s death. This right to refuse medical treatment, however, is not absolute. The state maintains an interest in preserving life which may conflict with this personal interest of privacy. The Supreme Court has made it clear that when such a conflict arises, a balancing test must be applied. The underlying state interests must be identified and then weighed against the harm to the patient’s interests which would result from allowing the patient to die. In addition to the compelling state interest in preserving life, the courts have found compelling state interests in preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. When the ex-

17. See, e.g., Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In Re Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976); cf. John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971) (where only 5 years prior to Quinlan the New Jersey Supreme Court held that “there is no constitutional right to choose to die.” Id. at 580, 279 A.2d at 672).

18. In fact, the Supreme Court has recently curtailed the trend of a broad interpretation of the notion of a privacy right in Bowers v. Hardwick, 106 S. Ct. 2841 (1986) (where the Court upheld the contested Georgia sodomy statute by essentially stating that private, adult consensual homosexual conduct is not protected by the constitutional right to privacy).

19. See supra note 11.

20. Saikewicz, 373 Mass. at 740, 370 N.E.2d at 424; In Re Quackenbush, 156 N.J. Super. 282, 290, 383 A.2d 785, 789 (Morris County Ct. 1979) (patient who could have undergone operation to amputate both gangrenous legs was permitted to refuse operation); In Re Quinlan, 70 N.J. at 40, 355 A.2d at 663.


23. Id.

24. See In Re President & Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) (blood transfusion ordered by Judge Wright for Jehovah’s Witness whose religious beliefs made such procedure abhorrent, over refusal by patient’s husband to give consent); John F. Kennedy Memorial Hosp., 58 N.J. 576, 279 A.2d 670 (blood transfusion ordered for Jehovah’s Witness patient who could not give consent because of extreme shock). The New Jersey Supreme Court distinguishes these cases from Quinlan and Conroy type cases because the patients were apparently “saveable to long life and vibrant health.” In Re Quinlan, 70 N.J. at 39, 355 A.2d at 663.

25. See In Re Caulk, 125 N.H. 226, 231-32, 480 A.2d 93, 96-97 (1984) (attempt by otherwise healthy state prisoner to starve himself to death because he preferred death to life is considered attempted suicide and state could force him to eat).

26. See Saikewicz, 373 Mass. at 742, 370 N.E.2d at 426 (acknowledging the institutional considerations of maintaining the ethical integrity of the medical profession by allowing hospi-
ercise of a patient’s right to refuse treatment is outweighed by any of these
overriding state interests, a patient’s request to withdraw treatment will be
denied. 28

In the absence of a definitive ruling on the issue by the Supreme Court,
some state courts have refused to find a right of privacy when the issue of
discontinuing life-sustaining medical treatment arises. For instance, the
New York Court of Appeals has refused to consider the privacy question in
a right to die case, resolving the matter instead based on the common law
right to be free from bodily intrusions. 29 In In Re Storar, the same New
York court allowed a patient’s removal from a respirator based on this com-
mon law right. 30

The exercise of the right to refuse medical treatment is less certain, how-
ever, when asserted by a third party guardian for the incompetent patient.
Although usually permitted, the courts have not yet adopted a uniform stan-
dard to apply in these cases. Basically the question is one of the best interest
versus substituted judgment. 31 The traditional best interest standard, ap-

tals to provide care for people under their control. N.B., however, that with this 67-year-old
mentally retarded man who developed leukemia, the Massachusetts Supreme Judicial Court
allowed him to die.) See also In Re President & Directors of Georgetown College, 331 F.2d 1000;

27. See, e.g., Jacobson v. Massachusetts, 197 U.S. 11 (1905) (validating the enforceability
of mandatory smallpox vaccination laws); Holmes v. Silver Cross Hosp., 340 F. Supp. 125, 130
(N.D. Ill. 1972) (overruling parental objections to life-saving blood transfusions to save a mi-
nor child’s life).


29. The common law right to be free from bodily intrusions stems from a cause of action
in trespass upon the person. As Justice Cardozo stated while sitting on the New York Court of
Appeals in the 1914 case of Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 127,
105 N.E. 92, 93 (1914), “Every human being of adult years and sound mind has a right to
determine what shall be done with his own body; and a surgeon who performs an operation
without his patient’s consent commits an assault for which he is liable in damages . . . .” See
also Natanson v. Kline, 186 Kan. 393, 408, 350 P.2d 1093, 1104, clarified, 187 Kan. 196, 354
P.2d 670 (1960) (the right to decline nonconsensual medical treatment was explicitly stated for
the first time).

858 (1981) (the court here balanced the common law right to be free from bodily intrusions
against the state interest in preserving life similar to the way this test has been applied in the
privacy cases).

31. Best interest is the traditional notion that the physician should do everything possible
that would be in the “best interest” of the patient for his recovery, whereas the doctrine of
substituted judgment is the method by which a guardian, in making a decision for his ward,
tries to determine what decision the ward would have made, if able, under the circumstances.
For a more detailed explanation of the differences, see Saikewicz, 373 Mass. at 751-52, 370
N.E.2d at 430-31 (for historical background and modern use of substituted judgment); Weber,
Substituted Judgment Doctrine: A Critical Analysis, 1 ISSUES L. & MED. 131 (1985); see also
plied prior to the advent of high-tech health care, allowed decisions to be made for incompetent patients based upon the perceived best interest of the patient. This usually translated into directives for the administration of all treatment necessary to preserve life. However, with the onslaught of advanced medical technology which increases the ability to prolong life by using mechanical devices, there has been a growing trend towards allowing decision-making for the incompetent patient based on a standard of substituted judgment. This method takes into consideration what the patient would want were he competent to decide. The standard can include cessation or withdrawal of life-sustaining treatment provided that it qualifies as "extraordinary care," notwithstanding its availability, based on the well-established right to refuse medical treatment.

The paradigmatic situation involves a decision whether to discontinue or refrain from initiating a treatment which will maintain the life of an incompetent patient, but which will not affect a cure. Artificial respiration and mechanical dialysis traditionally fall into this category. Several recent state court cases have added to this category of medical devices the nasogastric and gastronomic feeding tubes. Treatment by these tubes may be painful and expensive, while failure to treat may result in accelerated or immediate death. It is not at all clear, however, whether these artificial/mechanical feeding devices qualify as "extraordinary" medical treatment. This dilemma has resulted in a deluge of applications to courts by legal guardians for rulings on what their obligations are with respect to patients who are being kept alive by such feeding tubes.

In *In re Quinlan*, the New Jersey Supreme Court disallowed evidence of the patient's hypothesized intent in keeping with the traditional notion of best interest. The *Conroy* court expressly rejected this portion of the *Quinlan* decision by adopting a limited objective test which allows direct evidence demonstrating what the patient's intent may have been and gives credence to the doctrine of substituted judgment. The court stated that "such evidence

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33. *Id.* at 806, 823-24.
37. Corbett, 487 So. 2d at 368; *In Re Jobes*, No. C-4971-85E, slip op. at 12.
38. *In Re Quinlan*, 137 N.J. Super. at 260, 348 A.2d at 801.
39. *In Re Conroy*, 98 N.J. 321, 362, 486 A.2d 1209, 1230 (1985) (To the extent that *Conroy* conflicts with *Quinlan*, *Quinlan* was expressly overruled).
is certainly relevant to . . . whether the patient would have consented to the
treatment if competent to make the decision." The Conroy court went on
to cite living wills as an example of a form this needed evidence may take.\footnote{40} In keeping with this evolutionary trend, and possibly taking it one step fur-
ther, the trial court in Brophy held that the right to refuse medical treatment,
extended to the incompetent patient, "is to be exercised through a 'substit-
tuted judgment' on his behalf."\footnote{42} When a patient's right to reject treatment
was weighed against the state's interest in preserving life, the Brophy court
stated:

[In certain, thankfully rare circumstances the burden of maintain-
ing the corporeal existence degrades the very humanity it was
meant to serve. The law recognizes the individual's right to pre-
serve his humanity, even if to preserve his humanity means to al-
low the natural processes of a disease or affliction to bring about a
death with dignity.\footnote{43}]

The Supreme Judicial Court of Massachusetts thus allowed Brophy's substi-
tuted judgment to prevail by issuing a final order which would facilitate the
removal of his feeding tube either at another hospital or at home.

As the law presently stands, the federal constitutional right of privacy
extends to a patient who wishes to refuse medical treatment when that right
is not outweighed by certain state interests. Given the existence of this right,
it is now clear that it may be exercised by the incompetent patient. How-
ever, when a third party attempts to exercise this right on behalf of the in-
competent patient the courts must apply a balancing test. The court will
consider whether there are countervailing state interests which outweigh the
decision to exercise this right. Among the state interests which have been
identified in prior cases are: (1) the preservation of life,\footnote{44} (2) the protection
of the interests of innocent third parties,\footnote{45} (3) the prevention of suicide,\footnote{46}

\footnote{40} Id.
\footnote{41} Id. at 363, 486 A.2d at 1230-31. A living will is a declaration which provides instruc-
tions to one's family and physicians on what to do should one become incompetent and a
decision must be made as to whether extraordinary medical care should be used and/or contin-
ued. These declarations are sometimes statutorily and judicially sanctioned. \textit{E.g.}, John F.
Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); \textsc{Cal. Health \\& Safety
Code} §§ 7185-95 (West Supp. 1985); see generally Comment, \textit{Living Will: Already a Practical
\footnote{42} Brophy v. New England Sinai Hosp., No. 85 E 00090-G1, slip op. at 30 (Oct. 21,
1985).
\footnote{44} See cases cited supra note 24.
\footnote{45} See, \textit{e.g.}, Jacobson v. Massachusetts, 197 U.S. 11, 37 (1905) (recognizing enforceabil-
ity of compulsory smallpox vaccination law); Holmes v. Silver Cross Hosp., 340 F. Supp. 125,
130 (N.D. Ill. 1972) (indicating that patient's status as father of minor child may justify au-
thorizing blood transfusion to save his life, despite his religious objections); Commissioner of
and (4) the maintenance of the ethical integrity of the medical profession. Each court, then, on a case by case basis, must apply the balancing test to determine when a third party guardian may exercise the constitutional right on behalf of an incompetent patient.

II. A COMPARATIVE ANALYSIS OF THE CASES DEALING WITH A THIRD PARTY REQUEST TO REMOVE A NUTRIENT FEEDING TUBE FROM THE INCOMPETENT PATIENT: WHAT STANDARDS SHOULD APPLY?

A. The Conroy Case: A Medical Dilemma Seeking a Legal Answer

Claire Conroy led a rather secluded life, living alone, with few friends and never marrying. Thomas Whittemore, her nephew and only surviving blood relative, was appointed guardian ad litem when she became incompetent in 1979. He testified before the trial court that Miss Conroy feared and avoided doctors and that to the best of his knowledge she had never visited one until she became incompetent. Mr. Whittemore decided not to consent to the amputation of Miss Conroy’s gangrenous leg in 1982, based on substituted judgment. He then sought removal of the nasogastric tube, which was providing nourishment to her, on the same basis. He was of the opinion that were she competent to decide for herself, she would not have allowed its insertion in the first place and would not have consented to its

Correction v. Myers, 379 Mass. 255, 399 N.E.2d 452 (1979) (compelling prisoner to submit to necessary kidney dialysis over his protest in order to get transfer to lower security prison).

46. See In Re Caulk, 125 N.H. at 226, 480 A.2d at 96-97 (1984) (state was permitted to force otherwise healthy prisoner to eat in light of his attempt to starve himself to death. Prisoner stated that he preferred death to life in prison which the court considered attempted suicide).

47. See Bouvia v. County of Riverside, No. 159780, slip op. at 4 (Cal. Super. Ct. Dec. 16, 1983) (competent, non-terminal patient with severe cerebral palsy who refused to eat could not demand that health care providers help her commit suicide); cf. Justice Nolan’s dissent in the Brophy case which demonstrates that there is still much dispute as to how these interests are to be weighed against one another:

[I] can think of nothing more degrading to the human person than the balance which the court struck today in favor of death against life. It is but another triumph for the forces of secular humanism (modern paganism) (sic) which have now succeeded in imposing their anti-life principles at both ends of life’s spectrum.

Brophy, No. 4152, slip. op. at 2 (Nolan, J., dissenting).


50. Id.

51. Id.

52. See discussion on substituted judgment supra note 31.

continuance.

Miss Conroy’s physicians testified as to her condition at the time removal of the feeding tube was sought. Although not brain dead, her intellectual capacity was very limited and her mental condition, they testified, would never improve. In fact, several doctors stated that even with the excellent care she was receiving, Miss Conroy had perhaps a few months to live. She was suffering from severe organic brain syndrome, a gangrenous foot, ulcers on her left leg and hip, urinary tract infection, arteriosclerotic heart disease, hypertension and diabetes. She could neither control her bowels nor speak; her ability to swallow was very limited and she was unable to move from a semi-fetal position. Testimony regarding her capacity to experience pain was inconclusive. Given the “hopelessness” of her condition, and in light of her ongoing suffering, her physician recommended that the feeding tube be removed. He classified her medical treatment as being extraordinary or optional.

Reverend Joseph Kukura, a Roman Catholic priest and Professor of Christian Ethics at the Immaculate Conception Seminary in Mahwah, New Jersey, agreed with the doctor, relying upon a Vatican report on euthanasia. The test that the Church proffered required weighing the burdens against the benefits of continued existence through the aid of extraordinary life-sustaining medical treatment. Extraordinary treatment is defined in this report as procedures which are burdensome or inconvenient or which offer no hope of benefit to the patient. Father Kukura concluded that the use of the nasogastric feeding tube was extraordinary in this case and that it would be morally and ethically permissible to remove it.

54. Id. at 338, 486 A.2d at 1216.
55. The criteria for brain death include “absence of response to pain or other stimuli, pupillary reflexes, corneal, pharyngeal and other reflexes, blood pressure, spontaneous respiration, as well as ‘flat’ or isoelectric electroencephalograms and the like, with all tests repeated ‘at least 24 hours later with no change.’” In Re Quinlan, 70 N.J. 10, 27, 355 A.2d 647, 664 (1976) (quoting 1968 Report of the Ad Hoc Committee of the Harvard Medical School).
56. In Re Conroy, 98 N.J. at 339, 486 A.2d at 1217.
57. Id. at 339, 486 A.2d at 1218.
58. Id. at 337, 486 A.2d at 1217.
59. Id. at 338, 486 A.2d at 1218.
60. Id.
61. Id.
62. Id. at 339, 486 A.2d at 1219.
63. Id. Miss Conroy was a Roman Catholic.
64. Id. at 340, 486 A.2d at 1218 (citing VATICAN CONGREGATION FOR THE DOCTRINE OF FAITH, DECLARATION ON EUTHANASIA (June 26, 1980)).
65. See id. at 340, 486 A.2d at 1218.
66. Id.
The trial court decided to permit removal of the feeding tube. The question on appeal was whether Claire Conroy's right to privacy outweighed the state's interest in preserving her life. In phrasing the issue as such, the appellate court presumed that Miss Conroy's constitutional right of privacy to refuse medical treatment could extend to removal of the feeding tube.

The appellate division then ruled against the trial court, concluding that withdrawal of Miss Conroy's nasogastric tube would be tantamount to killing her — not simply letting her die — and that such active euthanasia was legally and ethically impermissible. Miss Conroy subsequently died with the nasogastric tube in place.

The Supreme Court of New Jersey thereupon took up the case with a very narrow focus. The court stated that it would determine the circumstances under which life-sustaining treatment may be withdrawn or withheld from an incompetent elderly nursing home patient who is suffering from serious and permanent mental and physical impairments, and who will probably die within approximately one year even with treatment. The court's decision presents and outlines three separate tests which it considered appropriate standards for making these treatment decisions.

The first standard proffered by the court was the "subjective test." Based on a guardian's substituted judgment, this test is applied when clear and convincing evidence indicates that the patient would refuse treatment under the circumstances, were he competent to do so. Acceptable evidence here

68. Id.
69. There is some dispute among scholars as to whether the state should have the power to make these quality-of-life-decisions. See Destro, Quality of Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent, 2 J. CONTEMP. HEALTH L. & POL'Y 71 (1986); see also Child Abuse Amendments of 1984, Pub. L. No. 98-457, 98 Stat. 1749 (1984) (to be codified at 42 U.S.C. §§ 701-5113) (where Congress has mandated that seriously ill infants be fed in all cases); Brief Amicus Curiae of George P. Smith, II, Bowin v. America Hosp. Ass'n, 106 S. Ct. 2101 (1986); Smith, Defective Newborns and Government Intermeddling, 25 MED. SCI. & LAW 44 (1985).
70. In Re Conroy, 98 N.J. at 335, 486 A.2d at 1218.
71. See sources cited supra note 5.
72. In Re Conroy, 98 N.J. at 335, 486 A.2d at 1218.
73. Id. at 98 N.J. at 342, 486 A.2d at 1219; but see Annas, When Procedures Limit Rights: From Quinlan to Conroy, 15 HASTINGS CENTER REP. 24 (Apr. 1985) (where the author suggests that a limited focus on nursing home patients instead of the patient's wishes and interests is mistaken). Dr. Annas criticized the Conroy court for ignoring the plight of Claire Conroy. Id. at 26.
74. In Re Conroy, 98 N.J. at 342, 486 A.2d at 1219.
75. For a definition of substituted judgment see supra note 31.
76. In Re Conroy, 98 N.J. at 360, 486 A.2d at 1229.
would be a living will.\textsuperscript{77} The court makes clear that the evidence used to apply this test must be clear and expressly on point as to the patient's wishes. The court neglects, however, to place a needed "stop-gap" on this test in light of a well established state policy against suicide.\textsuperscript{78} It is arguable that this test could come dangerously close to some of the questions dealing with the distinctions between "orders not to resuscitate" and suicide.\textsuperscript{79} The resulting confusion may demonstrate the need for legislative guidelines in these cases to determine which threshold factors will allow this subjective standard to be applied. In several instances, state legislatures have addressed the issue in natural death acts which set forth the procedures for the living will.\textsuperscript{80} The subjective test has every potential to be a very good one, as it is most in keeping with the patient's wishes. It simply needs to be structured to provide certainty so that it may be applied by the family and physicians in comfort and good conscience.

The second standard offered by the Conroy court was the "limited objective test."\textsuperscript{81} This test is applied when there is no clear and convincing evidence of the patient's wishes, but where there is some trustworthy evidence that the patient would have refused the treatment. This second test is based upon the theory of "best interest" of the patient. Consideration is given to medical evidence in weighing the burdens of continued life against the benefits of life given the continued treatment.\textsuperscript{82} It should be noted here that this very same court expressly rejected this approach in Quinlan. There, the New Jersey court held that evidence from family members regarding this issue was "remote and impersonal, . . . [and lacking] in significant probative weight."\textsuperscript{83} To the extent that the test in Conroy conflicted with the holding of Quinlan, it was overruled.\textsuperscript{84} This appears to be a positive step toward

\textsuperscript{77} Id. at 361, 486 A.2d at 1229. A living will is a document in which a person directs that certain artificial life support measures not be initiated or be discontinued under certain circumstances. See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment 139-41 (1983). At least 20 states and the District of Columbia have passed "living will" legislation. See also Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1985); D.C. Code Ann. §§ 6-2421 to -2430 (Supp. 1986) See generally Reaves, supra note 10.

\textsuperscript{78} See generally Note, Suicide and the Compulsion of Life Saving Medical Procedures: An Analysis of the Refusal of Treatment Case, 44 Brooklyn L. Rev. 285 (1978).


\textsuperscript{80} See supra note 8; see also discussion on living wills infra part IV.

\textsuperscript{81} In Re Conroy, 98 N.J. at 365, 486 A.2d at 1232.


\textsuperscript{83} In Re Quinlan, 70 N.J. 10, 22, 355 A.2d 647, 653 (1976).

\textsuperscript{84} In Re Conroy, 98 N.J. at 362, 486 A.2d at 1230; see also Cantor, Quinlan, Privacy and the Handling of Incompetent Dying Patients, 30 Rutgers L. Rev. 243 (1977).
including the patient's wishes in cases of medical decision-making for the incompetent patient.

Finally, the third test the court provides is the "pure objective test." This test is to be applied when there is no trustworthy evidence to establish whether the patient would have declined treatment. Furthermore, the medical evidence must establish that the net burdens of the patient's life with the treatment outweigh the benefits that the patient receives when the treatment is delivered. Where the treatment is so severe and unavoidable that administering it would be inhuman, the parties may opt to discontinue the treatment. This pure objective test takes into account more than the other two tests: the question of the quality of the patient's life is considered here. Whereas the first two tests allow for evidence of the patient's intent, the third one is used specifically in the absence of this sort of evidence. Therefore, in place of the "substituted judgment" considerations, therefore, the court brings in a quality-of-life analysis. Many commentators believe that the decision made for the incompetent patient must always incorporate this analysis.85

B. Brophy: Recognition of a Single Standard Whose Time has not Come

At approximately midnight on the evening of March 22, 1983, Paul Brophy awoke complaining to his wife of a "splitting" headache. He rolled over in bed, never to regain consciousness. The fireman and emergency medical technician from Easton, Massachusetts who enjoyed deer hunting, fishing, gardening and performing household chores had suffered serious and irreversible brain damage. The CAT Scan performed that early morning revealed subarachnoid bleeding in the posterior fossa surrounding the upper brain stem. A later angiogram revealed an aneurysm located at the apex of the basilar artery. On April 6, 1983, surgery was performed, a right frontotemporal craniotomy. Postoperatively, Mr. Brophy showed no response to verbal stimulation, remained unconscious, and exhibited only slight movement in his upper extremities in response to deep pain. A tracheotomy was performed after he was removed from the respirator and nutrition was provided by a nasogastric feeding tube.

Mr. Brophy's condition appeared hopeless. After Mr. Brophy showed no response to intensive physical therapy for four weeks, it was discontinued. His neurologists, Doctors Russell Butler and Ronald Cranford, who testified at the trial, reported that Mr. Brophy showed no response to verbal stimuli, had no "purposeful" movement, and was unable to interact or communicate

through eye movement, body movement or facial expression. He was diagnosed as being in a vegetative state with less than one percent likelihood of ever regaining cognitive functioning. After Mr. Brophy contracted pneumonia in August 1983, Mrs. Brophy, in consultation with her five children, informed the hospital personnel that it was her desire to have a “Do Not Resuscitate Order” (“DNR”) entered on her husband’s chart. Effectively, this meant that should Mr. Brophy experience cardiac arrest, the hospital staff was not to administer cardio-pulmonary resuscitation (“CPR”).

In keeping with acceptable medical procedures, the nasogastric feeding tube was replaced by a gastronomy tube which involved the surgical creation of a stoma through the abdominal wall and into the stomach. A tube is inserted in this hole and the patient is fed four times a day by pouring liquid food supplement (similar to baby food) into a plastic bag connected to the tube. It was the removal of this feeding tube that Mrs. Brophy sought in January 1985, after agonizing over the decision with her family and parish priests.

Mrs. Brophy’s request was first denied by her husband’s attending physician, Dr. Lajos Koncz, and later by the hospital’s Physician-in-Chief, Dr. Richard Field, who reasoned that the removal of the gastronomy tube would constitute an unethical medical practice as a “harmful act which would deliberately produce [Brophy’s] death.” The trial court found that aside from Mr. Brophy’s irreversible brain damage, the “general state of [his] health is relatively good.” The court observed that Mr. Brophy had at no time been diagnosed as being terminally ill and that “he is not in danger of imminent death from any underlying medical illnesses.” The physicians and staff of the New England Sinai Hospital were permanently enjoined from either removing or clamping the gastronomy tube for the purpose of denying Mr. Brophy the hydration and nutrition required to sustain his life, thereby denying Mrs. Brophy’s request.

It is important to remember that the court did look to what the patient’s wishes would be. Effectively, the trial court recognized and adopted the substituted judgment theory. Notwithstanding the lack of “hard evidence,” (i.e., the existence of a living will), the court accepted testimony from family members as to what the patient’s wishes would have been. The trial judge found that Mr. Brophy’s decision “would be to decline the provision of food

87. Id.
88. Id. at 45.
89. Id. at 17.
90. Id. at 13.
and water, and thereby terminate his life."

The judge concluded that the basis of Mr. Brophy's decision would be "the present quality-of-life possible for him, and would not be based upon the burdens imposed upon him by receiving food and water through a G-tube, which burdens are relatively minimal, inasmuch as the aforesaid treatment is neither painful nor invasive." This projection made by the court must be seen as speculative at best. It appears that the trial judge may have been attempting to demonstrate his disdain for a quality-of-life analysis. The fact that a patient had expressed his wishes based on a quality-of-life analysis should not in any way undermine what his intentions were. As long as the patient's wishes do not cross into the realm of suicide, the notion of substituted judgment based on a quality-of-life view should be considered appropriate.

State legislatures may adopt this subjective test by amending the state's living will statutes in a way which establishes that a validly executed living will is presumptively determinative in these situations. For example, where a guardian is seeking removal or withdrawal of "medical treatment" (including, for purposes of this example, a nasogastric feeding tube) from the incompetent nursing home resident (or "elderly") patient and where there is a validly executed living will from the patient directing such removal, the court need not look any further. The physician's certification of a persistent vegetative state coupled with proof of intrusive or extraordinary mechanical devices being used to sustain "life" should be sufficient for the courts to order that patient's directives be carried out.

In essence, the legislators would be providing the judiciary with a sort of checklist. This could help to validate the living will as well as to expedite the proceedings. The originally intended use for living wills was to provide direction to the family and health care professionals when the difficult decision of whether or not to artificially extend someone's life needs to be made. The subjective test, then, is clear and effective when triggered by use of a living will. To do otherwise is to provide no incentive to execute a living will. If an individual is given no hope that his wishes are going to be carried out, why execute a living will? Establishing, by statute, a procedure by which the courts could effectuate a living will would provide the necessary incentive.

91. Id. at 12.
92. Id. at 22.
III. APPLYING THE STANDARDS: WHEN CAN THE GUARDIAN EFFECTUATE A DECISION TO WITHDRAW TREATMENT?

A. Reviewing the Conroy Procedures

Because Miss Conroy was a patient in a nursing home when the action was brought, the court focused its holding very narrowly on patients who are similarly situated, namely, nursing home residents. Some have criticized the Conroy court for this narrow focus, maintaining that it can seldom be employed. G 93 It is quite possible that in many cases, when the patient’s medical problems have risen to the level where a guardian would need to decide whether to stop or withhold further medical treatment, the patient has already been removed from the nursing home and placed in a hospital. Thus the decision would fall outside the reach of all procedures sanctioned by the Conroy court.

Notwithstanding this practical barrier, a brief review of the procedures adopted by the Conroy court is helpful. The decision focuses almost exclusively on the New Jersey Elderly Abuse Statute. G 94 The 1983 amendments to the Act provide for the Office of the Ombudsman for the Institutionalized Elderly to guard against and to investigate allegations of elderly abuse. G 95 The court decided that every request for the withdrawal of life-sustaining treatment from an institutionalized elderly patient would necessarily require notification of the Office of the Ombudsman. Upon notification, that office is to begin with the presumption that “abuse” within the meaning of the statute exists. G 96 The ombudsman would then conduct an investigation and issue a report within twenty-four hours to the Commissioner of Human Services and to any other government agency that regulates or operates the facility. G 97 This investigation requires collection of information regarding the patient’s condition from the attending physicians and nurses. In addition, two other physicians unaffiliated with the nursing home must confirm the condition and prognosis reported by the attending physician. G 98 The information provided must then meet the criteria for at least one of the three tests aforementioned: namely, that a showing of clear evidence, based in good faith that either the subjective, limited objective, or pure objective test was satisfied. The guardian, physicians and ombudsman must all agree that the criteria are met. Then, absent bad faith, all participants can withhold and withdraw

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93. See Annas, supra note 73.
95. Id.
97. Id.
98. Id.
medical treatment with legal immunity.\textsuperscript{99} When either the limited best interest or the pure-objective best interest test is used to reach this conclusion, the patient’s spouse, parents, and children, or in their absence, next of kin, must also concur.\textsuperscript{100} It has been asserted that these procedures are unnecessarily cumbersome.\textsuperscript{101} In addition, the procedures have been criticized for unnecessarily requiring concurrence of too many individuals.\textsuperscript{102}

The clearest indication of these tests being overly broad and unrealistic is the New Jersey court’s application of them to the facts in the \textit{Conroy} case. Although the facts there appeared to indicate that withdrawal of the feeding tube was appropriate, the court found that (were Miss Conroy still alive) the guardian would have to explore the issues further prior to reaching any decision.\textsuperscript{103} The court then warned that the procedures it offered should not be abused, by stating: “Guardians — and courts, if they are involved — should act cautiously and deliberately in deciding these cases. The consequences are most serious — life or death.”\textsuperscript{104} Since the \textit{Conroy} Court stated that it would not have permitted the removal of Miss Conroy’s tube, it affectively undermined what the decision appears to set out to do.

\textbf{B. The Need to Recognize Substituted Judgment: A Review of the Brophy Rationale}

Although the \textit{Conroy} court pays homage to the notion of substituted judgment in offering a subjective test based on the intentions of the patient, it does not go far enough. The \textit{Brophy} court, however, takes that extra step. Both at the trial court and supreme court level, the notion of substituted judgement is expressly recognized and embraced.\textsuperscript{105} In giving credence to the substituted judgment theory, the \textit{Brophy} court took the next logical step in the evolution of “right to die” cases. In fact, one of the concurring justices in the \textit{Brophy} case questioned whether acknowledgment of “substituted judgment” was not merely a recognition of a right to commit suicide. Justice O’Connor, who concurred in part and dissented in part, framed the issue in \textit{Brophy} as: “[w]hether the court shall honor the substituted judgment of a person in a persistent vegetative state that the artificial, effective, and non-burdensome maintenance of his nutrition and hydration be discontinued by

\begin{itemize}
\item \textsuperscript{99} Id.
\item \textsuperscript{100} Id.
\item \textsuperscript{101} See Note, supra note 3, at 1334; see also Note, \textit{In Re Conroy: Self Determination: Extending the Right to Die}, 2 J. CONTEMP. HEALTH L. & POL’Y 351 (1986).
\item \textsuperscript{102} Annas, supra note 73, at 25.
\item \textsuperscript{103} \textit{In Re Conroy}, 98 N.J. at 386, 486 A.2d at 1243.
\item \textsuperscript{104} Id.
\item \textsuperscript{105} \textit{Brophy} v. New England Sinai Hosp., No. 85 E 00090-G1, slip op. at 21 (Oct. 21, 1985); \textit{Brophy} v. New England Sinai Hosp., No. 4152, slip op. at 20 (Mass. Sept. 11, 1986).
\end{itemize}
others in order to bring about his early death."106 The justice goes on to reason, in a classic "slippery slope" argument, that acknowledgment of substituted judgment is simply judicial condonation of a right to suicide — at any age or state of health.

Fortunately, however, the majority opinion in Brophy stays as close as possible to a well reasoned analysis of when, and more importantly why, the doctrine of substituted judgment should be acknowledged. Specifically, the court in acknowledging substituted judgment may in fact be authorizing or recognizing a right to die, but it is a right to die a natural death with dignity.

IV. THE LEGISLATIVE ATTEMPT TO PROVIDE CERTAINTY IN THE AREA: A REVIEW OF THE "RIGHT TO DIE" LAWS

A. Documented Proof of an Individual's Intentions: The Living Will

Living wills find their genesis in what has been generally referred to as the "Right to Die" laws.107 These state statutes provide for a declaration to be executed which establishes directives (usually to the physicians and family) that declarants' lives are not to be artificially prolonged following a medical determination of imminent death, or in some cases, of irreversible injury which results in a vegetative state.108 These state statutes vary in specificity and applicability.109 (In short, some are good and some are not so good). For purposes of providing clear direction in the area of decision-making for the incompetent adult, there remains much work to be done.110

Most statutes provide a sample living will as an example of what the legislators intended, although states sometimes allow for personal variations.111

106. Brophy, No. 4152, slip op. at 3 (O'Connor, J., concurring in part and dissenting in part) (emphasis added).


108. Four of the states require that the model declaration form be used exactly. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1986); GA. CODE ANN. 31-32-1 (1985); IDAHO CODE § 39-4504 (1985); OR. REV. STAT. § 97.055 (1985). Wisconsin requires the State Department of Health and Social Services to distribute a declaration form contained in the statute, but the statute does not state that the form is obligatory. WIS. STAT. ANN. § 154.11 (West Supp. 1986).

109. For example, the Idaho code provides for execution of a living will only after a determination of terminal illness has been made. IDAHO CODE §§ 39-4503 (3), 39-4504 (1985). By contrast, the Oklahoma code provides that a living will must be executed (or re-executed) after a diagnosis of terminal illness has been made in order for the living will to be binding; otherwise, it may be offered as evidence of the patient's state of mind, but is not determinative. OKLA. STAT. ANN. tit. 63, § 3107 (c) (West Supp. 1987).

110. See Note supra note 10.

111. For example, the District of Columbia law provides that the "declaration shall be substantially in the following form, but in addition, may include other specific directions,"
Others, however, require that the specific form set forth in the statute be used for the document to have legally binding effect. For example, the District of Columbia Code provides, in pertinent part, that the “declaration shall be substantially in the following form, but in addition may include other specific decisions,” not inconsistent with the remainder of the Natural Death Act:

DECLARATION

Declaration made this ______ day of ________, ________

I, __________________________, being of sound mind, willfully
and voluntarily make known my desires that my dying shall not be
artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed:______________________________

Address:______________________________

______________________________

I believe the declarant to be of sound mind. I did not sign the declarant’s signature above for or at the direction of the declarant. I am at least 18 years of age and am not related to the declarant by

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which are not inconsistent with the remainder of the District’s Natural Death Act. D.C. CODE ANN. § 6-2422 (Supp. 1986).

112. See sources cited supra note 107.

blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

Witness: ________________________________

Witness: ________________________________

The living will is usually effective until revoked in a manner authorized by the statute, although in three states it is effective only for five years, and in one it is effective for seven years and must be executed anew at that time. Some states, in cases where the patient is still mentally competent, require that the living will directive be superseded by the present desires of the patient.

The legally binding effect of a living will depends in large part on the language of the applicable state statute. For example, three states provide that a declaration is not legally binding unless it is executed after the declarant has been diagnosed as terminally ill. Each of these state statutes establishing procedures for an individual's "right to die" provide criminal, civil and professional immunity to physicians and other health professionals who comply in good faith with the provisions of a validly executed living will. Compliance with the directive in the living will usually require that

114. Id.
115. See, e.g., D.C. CODE ANN. § 6-2424 (Supp. 1986) which provides for revocation by: (1) destruction of the document; (2) by written revocation — provided it is communicated to the physician, or (3) by verbal expression by the declarant — provided it is done in the presence of a witness and is communicated to the attending physician.
120. For example, the Delaware statute specifies that health care providers are immune from liability unless negligent. The pertinent portions of this act provide: "There shall be no criminal or civil liability on the part of any person for failure to act in accordance with a revocation, unless such person had actual or constructive knowledge of the revocation." DEL. CODE ANN. tit. 16, § 2504(b) (1983). The Act additionally states that:

Physicians or nurses who act in reliance on a document executed in accordance with this chapter, where such health care personnel have no actual notice of revocation or contrary indication, by withholding medical procedures from an individual who executed such document shall be presumed to be acting in good faith, and unless negligent shall be immune from civil or criminal liability.

the physicians have a confirmation of the diagnosis and prognosis and that the certification of the terminal condition be in writing. Most of these acts provide that physicians must comply with a declaration in the living will, or transfer the patient to another physician who is willing to do so. Furthermore, statutes provide that failure to comply with a declaration may constitute unprofessional conduct. The Nevada statute is unique in this regard. It provides that the physicians are not legally bound even by a properly executed living will and are permitted to take into account any “other factors” in deciding whether or not to withdraw or withhold life-sustaining measures. This is an example of legislative action prompting inaction. If the thrust of this type of legislation is to allow an individual to make his own decision about whether or not to artificially extend his “life,” then the statutes must accordingly provide full recognition to a validly executed living will.

B. Parameters for Execution of a Living Will Declaration and the Need for Certainty

The requirements that state legislatures have set forth for the execution of living wills are somewhat analogous to those for traditional wills. Both are required to be in writing and have witnesses. (It should be remembered that the purpose of an ordinary last will and testament is to pass property and that it only speaks upon death). The reason for requiring rigid formalities for testamentary execution of traditional wills is to provide certainty. Once


122. See, e.g., D.C. CODE ANN. § 6-2425, § 6-2427(b) (Supp. 1986).


125. See generally T. ATKINSON, LAW OF WILLS (1953).
effective, its maker is unavailable to provide clarification should doubt arise. The formal testamentary requirements were thus established to provide this certainty. The purpose of a living will, on the other hand, is to provide direction to family and physicians as to what medical treatment is or is not permissible in certain situations. Although the living will arguably speaks before death, the same considerations for certainty are present as with the traditional will. Specifically, the declarant is also unavailable, not because of death, but because of a comatose state. In giving legal effect to the living will, courts will need to establish that the individual declarant is unavailable and therefore unable to provide clarification or direction as to his intent in much the same way as a testator would. The living will then speaks for the declarant at the happening of these events. There is a need for state statutes establishing living wills to provide for execution formalities in a way similar to that which the Wills Act126 and the Statute of Frauds127 do for a regular will to provide the same needed certainty. The courts are in a better position to validate living wills and use them as rebuttable presumption evidence of the patient's intent—in effect validating the notion of substituted judgment. The problem, however, is that the living will statutes do not always provide certainty.128 To ascertain whether a statute effectively adheres to an individual's intentions, one must first examine the execution provisions of the law.

Most living will statutes have specific provisions for execution.129 All of these states except Arkansas130 provide that a requisite mental capacity is necessary before the document can be legally binding. This usually requires that the declarant attest to the fact that he is of sound mind and/or is emotionally and mentally competent at the time of the execution of the declaration.131 The Arkansas statute requires the same formalities for the execution of a living will as for the execution of an ordinary will.132 In addition to the

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126. Y.B. 32 Hen. VIII, c. 1 (1540).
127. Y.B. 29 Chas. II, c. 3 (1677).
128. The typical living will statute provides broad general language in terms of the "directive to physicians." As a result, notwithstanding the individual's intentions expressed in the living will, the physician has a great deal of discretion in terms of defining when the patient is "terminally ill," for example. For a good discussion of the physician's viewpoint, see Relman, The Saikewicz Decision: A Medical Viewpoint, 4 AM. J. L. & MED. 233 (1979).
129. For example, the District of Columbia statute provides that the declarant be "of sound mind and must make the directive willfully and voluntarily." D.C. CODE ANN. § 6-2422(c) (Supp. 1986). Additionally, the statute provides that, "[a] directive may be executed by any person 18 years of age or older, or by another person at the express direction of the declarant and in the declarant's presence." Id. at § 6-2422.
130. The Arkansas statute does, however, require that the formalities for execution of a will be followed. The Arkansas Probate Code specifies that a person must be of sound mind and eighteen years of age or older to make a will. Ark. STAT. ANN. § 82-3801 (1986).
131. Relman, supra note 128.
132. See supra note 129.
capacity requirement, fourteen of these statutes provide that the individual must attest to the fact that his execution of the living will was performed willfully and voluntarily.

In addition to mental prerequisites for execution, twenty-one of the thirty-six jurisdictions having these statutes specify that a declarant must have reached the age of majority or adulthood to be legally competent. The Illinois statute provides that an emancipated person (a minor who has demonstrated the ability to live on his own) may execute a living will. Only the North Carolina statute fails to indicate at what age a person is competent to make a declaration for a natural death, leaving the question open. The states of Arkansas, Louisiana and New Mexico, in their Natural Death Acts, provide for declarations to be executed by others on behalf of minors. The Alabama, District of Columbia and Kansas statutes take this one step further and provide for execution of a living will by a third party on behalf of a competent adult. The caveat here is that this third party execution for the competent adult must be done in the presence and at the express direction of the declarant. These procedures are similar to those required by many state statutes for the execution of a valid will by proxy.

With regard to living wills executed by patients in nursing homes or skilled nursing facilities, three of the state statutes require the declarations to be witnessed by an ombudsman or patient advocate for them to be valid.

133. ILL. ANN. STAT. ch. 110½, para. 703 (Smith-Hurd Supp. 1986).
134. However, the North Carolina statute contains a unique provision establishing procedures for the withholding or withdrawal of life-sustaining treatment in the absence of a declaration and where the following circumstances exist: (1) an individual is comatose and there is no reasonable possibility that he/she will return to a cognitive sapient state or is mentally incapacitated; (2) it has been determined by the attending physician that the person's present condition is terminal, incurable, and irreversible; (3) there is confirmation of the person's present condition in writing by a physician other than the attending physician; and (4) a vital function of the person could be restored by extraordinary means or a vital function of the person is being sustained by extraordinary means. Under these circumstances and in the absence of a declaration executed in conformance with the statute's requirements, the extraordinary means may be discontinued upon the direction and under the supervision of the attending physician at the request of, and in the following order: (i) the person's spouse, or (ii) a guardian of the person, or (iii) a majority of the relatives of the first degree. But if none of the above are available the extraordinary means may be discontinued upon the direction and under the supervision of the attending physician. N.C. GEN. STAT. § 90-322(a), (b) (1985).
135. ARK. STAT. ANN. §§ 82-3802, 82-3803 (Supp. 1985).
137. N.M. STAT. ANN. §§ 24-7-3A, 24-7-4 (1986).
141. CAL. HEALTH & SAFETY CODE § 7188.5 (West Supp. 1985); DEL. CODE ANN. tit. 16, § 2506(c) (1983); D.C. CODE ANN. §§ 6-2422, 6-2423 (Supp. 1986).
The Georgia statute provides that the declaration must be witnessed by the chief of the hospital medical staff or the medical director of the nursing facility when the patient is confined to a hospital or nursing home. These provisions attempt to alleviate the potential for abuse.

In an effort to alleviate problems which may arise under their state's strict formalities in living will execution, Delaware, Florida, Louisiana and Virginia have included in their statutes a provision whereby the declarant may designate another person to make the treatment decision should the declarant be rendered incapable of communicating. Although these particular provisions remain untested, there is some question as to whether this grant of authority would withstand judicial scrutiny in the absence of any specific standards upon which third parties may rely. The Arkansas statute arguably goes beyond reasonable boundaries for execution of these documents by allowing the declaration to be executed by a third party on behalf of incompetent adults without a prior designation by the individual. These grants of decisional authority for an incompetent patient are precisely the type of "slippery slope" which courts have attempted to avoid in many of the difficult "right to die" cases heretofore presented. It appears likely that this type of decision-making power would be more acceptable with certain boundaries or constraints placed upon it by the declarant himself. One such constraint may be to require that the declaration articulate some standard which the third party is to apply in making the decision. For example, certification by at least two physicians that death is imminent and there has been irreversible brain damage, or that the individual is in a persistent vegetative state. Then should judicial intervention be sought, the court would have a reasonable basis upon which to evaluate the third party's decision for the incompetent patient by applying the particular facts to the specific standard.

V. THE NEXT QUESTION: IS NOURISHMENT MEDICAL TREATMENT?

Given the ability of a guardian to exercise a right of privacy for the incompetent patient by denying consent for medical treatment under certain conditions, it was important for the Conroy and Brophy courts to determine exactly what constitutes medical treatment. Specifically, the courts had to decide the issue of whether the administration of an artificial feeding tube could be equated with other forms of treatment that have been held to be removable. Some courts have allowed removal of a mechanical respirator

143. DEL. CODE ANN. tit. 16, § 2502(a), (b) (1983); FLA. STAT. § 765.03 (West 1986); LA. REV. STAT. ANN. § 40:1299.58.3B(2) (West Supp. 1986); VA. CODE ANN. §§ 54-325.8:3, 54-325.8:4 (Supp. 1986).
144. ARK. STAT. ANN. §§ 82-3802, 82-3803 (Supp. 1985).
from a patient, pursuant to a guardian’s request and withdrawal of a patient from kidney dialysis treatment. These decisions, however, were based in part on the reasoning that it was only the mechanical devices that kept the patient alive and that the patient should be allowed to die a natural death. A doubt arises due to a notion that a nutrient feeding tube is basic sustenance which, if discontinued, would cause the patient to die of starvation, not a natural death. Even in the cases where a mechanical respirator was removed, feeding was continued.

The Conroy court, by contrast, was quick to include the nasogastric feeding tube within the realm of removable medical treatment. In discussing this issue, the court noted that it is difficult to shed the “emotional symbolism” of food, but went on to find that:

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

This analysis may be flawed in that it focuses on the wrong side of the question. It is undisputed that a mechanical feeding device (i.e., nasogastric feeding tube) assists in prolonging life when the bodily function can no longer act on its own, as a respirator would. However, the real question is whether the true effect of its removal is natural death or starvation. It is further undisputed that the removal of a feeding device will assure the death

147. See Callahan, On Feeding the Dying, 13 Hastings Center Rep. 22 (Oct. 1983) (which explains that when Karen Quinlan's father was asked if he wanted Karen’s intravenous feeding stopped he said, “Oh no, that is her nourishment.”). See also Lynn & Childress, Must Patients Always Be Given Food and Water?, 13 Hastings Center Rep. 17, 20 (Oct. 1983).
148. Lynn & Childress, supra note 147, at 20.
149. Cf. Barber v. People, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (Although this case was brought in a criminal context — specifically, a homicide prosecution for death resulting from withdrawal of life support systems — it was one of the first state court cases that equated artificial (here intravenous) feeding with all other artificial life support systems. Any distinction, this court noted, was based “more on the emotional symbolism of providing food and water to those incapable of providing for themselves, rather than on any rational difference.” Id.
of the patient,\textsuperscript{151} while removal of a respirator will not.\textsuperscript{152} Karen Ann Quinlan, for example, lived for ten years after the artificial respirator was removed. This was an unexpected event for those involved in her case, especially her physicians who had predicted that she would not live without artificial respiration. She continued, however, to receive an artificial supply of nutrition during those ten years.\textsuperscript{153}

In the case of Paul Brophy, the trial judge held that any patient who was to have a nutrient feeding tube removed would likely experience the following effects:

(a) His mouth would dry out and become caked or coated with thick material.
(b) His lips would become parched and cracked or fizzured (sic).
(c) His tongue would become swollen and might crack.
(d) His eyes would sink back into their orbits.
(e) His cheeks would become hollow.
(f) The mucosa (lining) of his nose might crack and cause his nose to bleed.
(g) His skin would hang loose on his body and become dry and scaly.
(h) His urine would become highly concentrated, causing burning of the bladder.
(i) The lining of his stomach would dry out and cause dry heaves and vomiting.
(j) He would develop hyperthermia, a very high body temperature.
(k) His brain cells would begin drying out, causing convulsions.
(l) His respiratory tract would dry out, giving rise to very thick secretions, which could plug his lungs and cause death.
(m) Eventually his major organs would fail, including his lungs, heart and brain.\textsuperscript{154}

Accordingly, that state trial court made a more well-defined distinction between removing various medical support systems of a mechanical nature and withdrawing the supply of food.\textsuperscript{155} In \textit{Brophy}, the trial court conceded that only where a patient is terminally ill or has reached the end of his nor-

\textsuperscript{151} \textit{Id}; see also \textit{Barber}, 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490 (1983).
\textsuperscript{153} To the surprise of most people including her physicians, Karen Ann Quinlan lived some 10 years beyond her removal from the artificial respirator. She died on June 15, 1985.
\textsuperscript{154} \textit{Brophy}, No. 4152, slip op. at 26.
\textsuperscript{155} \textit{Id}. at 27.
mal span of years, the distinction is less clear, intimating that under these latter circumstances the food may qualify as "extraordinary" care so as to be removable.\(^{156}\) However, although the *Brophy* trial court held that: "It is ethically inappropriate to cause the preventable death of Brophy by the delibera
denial of food and water, which can be provided to him in a noninvasive, nonintrusive manner which causes no pain and suffering, irrespective of the substituted judgment of the patient,"\(^{157}\) the Massachusetts Supreme Court disagreed. In the majority opinion, Justice Liacos stated that the determination that a feeding tube is extraordinary or ordinary care should not be the "sole or major" factor in these decisions.\(^{158}\) Rather, this creates what he termed a "distinction without meaning." The court stated, "Just as the distinction between extraordinary and ordinary arguably obsces the real issue, so, too, the distinction between withholding and withdrawing treatment has no moral significance."\(^{159}\) The Supreme Judicial Court of Massachusetts went on to find that Mr. Brophy's feeding tube was "not only intrusive, but extraordinary," and thus removable.\(^{160}\)

The *Conroy* court also fostered the notion that the feeding tube is treatment by noting that these procedures provide complications that are sometimes serious and distressing to the patient.\(^{161}\) The court noted that nasogastric tubes may lead to pneumonia, cause irritation and discomfort, and require arm restraints for incompetent patients.\(^{162}\) Moreover, the volume of fluid needed to carry nutrients itself is sometimes harmful.\(^{163}\)

Justice Schreiber, writing for the majority in *Conroy*, had a view of dehydration directly opposite from Judge Koplemann who wrote the recent *Brophy* decision in Massachusetts. Schreiber's analysis in *Conroy* suggests that:

For patients who are unable to sense hunger and thirst, withhold
ing of feeding devices such as nasogastric tubes may not result in more pain than the termination of other medical treatment. Indeed, it has been observed that patients near death who are not receiving nourishment may be more comfortable than patients with

\(^{156}\) *Id.*

\(^{157}\) *Id.* at 28.

\(^{158}\) *Id.* at 29.

\(^{159}\) *Id.*

\(^{160}\) *Id.* at 30.


\(^{162}\) *Id.*; Lynn & Childress, *supra* note 147, at 17-18.

\(^{163}\) Ferweich, *supra* note 161, at 51.
comparable conditions who are being fed and hydrated artificially. Thus, it cannot be assumed that it will always be beneficial for an incompetent patient to receive artificial feedings or harmful for him not to receive it.\textsuperscript{164}

The court then concluded that withholding or withdrawing artificial feeding would be permissible if there is sufficient proof to satisfy the subjective, limited-objective, or pure-objective test.\textsuperscript{165} The danger in allowing any court to adopt this type of analysis of feeding is that the judiciary takes on a combined role of judge, jury, doctor and God. It is quite possible that the characterization of nourishment as beneficial or harmful for the patient, are better left to the health care professionals and the families. The analysis is nearly unconscionable if one thinks of Conroy as the first step in judicially sanctioned starvation.

**CONCLUSION**

A critical review of the Conroy and Brophy decisions reveals the struggle of the judiciary in attempting to answer the questions involved in life and death decision-making for incompetent persons. Perhaps some of the confusion in these decisions is evidence of the fact that these questions are not strictly legal but are also medical, moral and religious.

Judicial intervention, however, is inevitable. As conflicts among physicians and between physicians and families arise, their resolution will invariably be sought in a court of law. With such a system, the judiciary must be attuned to all of the competing but legitimate interests. Beyond the obvious and overwhelmingly important state interest in preservation of life, the courts need to continue to strive for certainty. Living wills are examples of how the decisional void can be filled when addressing the life and death questions of the incompetent patient. Courts need to recognize what would have been the intentions of the patient were he competent to provide the necessary direction. An ideal demonstration of the incompetent patient's wishes is a living will.

Finally, whether a nasogastric feeding tube rises to the level of "extraordinary" medical treatment so as to be removable is probably a question better suited for the individual physicians and families involved, not the courts. The emotional stigma associated with withholding food is unfortunately ob-

\textsuperscript{164} In Re Conroy, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (citations omitted).

structing some individuals' views of the overall question: whether an individual does in fact have a right to die.

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