The Legal Aspects of Withdrawing Nourishment

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THE LEGAL ASPECTS OF WITHDRAWING NOURISHMENT

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INTRODUCTION

Approximately eight years have passed since the litigation over the medical treatment of Karen Ann Quinlan, a watershed in the ethical, religious, and legal debates over euthanasia, the definition of death, and the treatment of the dying and incurably ill. These debates, largely limited to the realms of academic medicine and ethics prior to Quinlan, are now staples of public policy. Evidence of this fact is pervasive: twenty-two states and the District of Columbia have passed “living will” or “natural death” legislation; more than a half-dozen state high courts have

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2 See Cantor, Quinlan, Privacy and the Handling of Incompetent Patients, 30 Rutgers L. Rev. 243 (1977); P. Ramsey, Ethics at the Edges of Life, 268–99 (1978); Death, Dying and Euthanasia 402–536 (Horan & Mall eds. 1980).
issued opinions recognizing a constitutional right to refuse life-saving treatment; the legal establishment has drafted and promulgated a Uniform Determination of Death Act which has been adopted in seventeen states and the District of Columbia; the federal government, and several state governments, have acted to set standards for the treatment of severely handicapped infants; and, a presidential commission on bio-


2. The Uniform Determination of Death Act (UDDA) was developed by a collaboration of the American Bar Association, the American Medical Association, the National Conference of Commissioners on Uniform State Laws, and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. See DEFINING DEATH (1981).

The UDDA states:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

States which have adopted the UDDA include Alaska, California, Colorado, Georgia, Idaho, Kansas, Maine, Maryland, Mississippi, Montana, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Washington, and Wisconsin. The District of Columbia has also adopted the UDDA.

3. Government involvement in this issue came largely in response to public controversy over the fate of “Infant Dec.”, a newborn with Down’s Syndrome born in Bloomington, Indiana in April, 1982. The infant was refused surgery to repair a tracheosophageal fistula and died six days after birth, never having been fed. President Reagan and the Department of Health and Human Services sought to prevent future such incidents by asserting that §504 of the Rehabilitation Act of 1973, 29 U.S.C. §794 (1983), which prohibits discrimination against handicapped individuals by recipients of federal funds, prohibited hospitals from denying medical treatment to handicapped infants. On May 18, 1982, the Secretary of HHHS issued a notice to health care providers stating that §504 made it unlawful for hospitals receiving federal financial assistance to withhold nutrition or medical or surgical treatment from handicapped infants if required to correct a life-threatening condition. 47 Fed. Reg. 26,027 (June 16, 1982). On March 7, 1983, more detailed regulations were issued which required the posting of notices in hospital nurseries stating that “discriminatory failure to feed and care for handicapped infants in this facility is prohibited by federal law” and giving a “hotline” phone number to which reports of suspected discrimination would be made. 48 Fed. Reg. 9630.

These regulations were challenged in federal court by the American Academy of Pediatrics and the National Association of Children’s Hospitals and Related Institutions, and invalidated on grounds that their promulgation did not conform to the requirements of the Administrative Procedure Act, 5 U.S.C. §551 et seq. A.A.P. et al. v. Heckler, 561 F. Supp. 395 (D.D.C. 1983). Revised regulations, which placed greater emphasis on the role of institutional review committees to handle difficult cases, and limited the posting of notices to areas accessible to medical personnel only, were promulgated in January 1984. 49 Fed. Reg. 1622 (Jan. 12, 1984). However, the United States Court of Appeals for the Second Circuit has subsequently held that §504 cannot be applied to medical treatment decisions involving handicapped newborns. United States v. University Hosp., 729 F.2d 144 (2d Cir. 1984).

ethics has issued a lengthy report on Deciding to Forgo Life-Sustaining Treatment, which, within one year, has become a standard reference point for addressing these issues.8

To a large extent, the flurry of legal activity in this area has produced a working consensus on the legal principles to be applied in a situation where the withdrawal of life-sustaining medical procedures is being considered. Courts have recognized that the withdrawal of useless and non-beneficial medical treatment that cannot and does not improve the prognosis for recovery of a terminally ill patient is a permissible exercise of medical judgment.9 In so doing, courts have specifically relied upon the ethical literature which draws a distinction between acts of “euthanasia,” where “passive” or “active” measures are taken to hasten death10 and acts of “antidysthanshipa,” where non-beneficial forms of treatment are withdrawn from a patient who is terminally ill, irremediably dying, and has no hope for recovery, thereby allowing the underlying illness to run its natural and inevitable course.11 There has thus emerged a medico-legal consensus that the distinction between recognizing and “allowing” the inevitability of death from the underlying illness, which is licit, and acting to hasten death, which is not,12 is valid and can be

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8 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983).
10 In re Quinlan, 70 N.J. 10, 46, 355 A.2d 647, 657 (1976);
We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable.
13 See Horan, The Quinlan Case, in DEATH, DYING, AND EUTHEANASIA 525, 533 (1977). A salient criticism of the Quinlan doctrine is that it elevates one criteria—patient choice—above all other factors which must necessarily come into play in medical decisionmaking for the terminally ill.
The Quinlan Court’s solution and other current proposals to legalize and regularize death's dispensation, to identify some among us—diseased person, doctor, judge—as ultimate and exclusive decision-maker, aborts the very process of communal collaboration by which each of us sustains our individual identity. The law should not offer to relieve everyone’s mutual distress if some among us will assume an identity, as exclusive choice-maker for all others, that none can coherently exercise.
Clinical considerations give additional cause to question the wisdom of a rule of law based primarily upon patient autonomy. Lo & Jonsen, Clinical Decisions to Limit Treatment, 93 ANNALS INTERNAL MED. 764, 766 (1981). The criteria of patient choice should be subject to
enunciated by the law without unduly threatening the rights of patients.\textsuperscript{13}

Despite this consensus, new ethical issues continually come to the forefront as a result of expanding medical technology,\textsuperscript{14} as well as agitation for change in the standards of medical ethics. Two areas where courts have been active recently are the treatment of handicapped newborns,\textsuperscript{15} and the question of whether mechanical means of nourish-

professional judgment regarding the circumstances surrounding the patient's purported decision, including the patient's level of information regarding treatment alternatives, the possible influence of sedation, pain or shock, and psychological conditions such as fear, anxiety, distrust, or depression. \textit{Id.} at 765. These authors conclude that of four possible criteria—futility of treatment, patient autonomy, quality of life, or cost of treatment—the first is the soundest reason for withdrawal of treatment, since the actual futility or usefulness of the treatment can be determined by the physician with the greatest degree of accuracy. "Experienced physicians will disagree over the details of an adequate therapeutic trial, such as the number of units of blood or days of supportive therapy. But at some point reasonable physicians could agree that further transfusions would be futile." \textit{Id.} at 764. Theologian Paul Ramsey has suggested a similar hierarchy of values in espousing a "medical indications" policy towards treating the seriously-ill and dying, both newborn and elderly. See P. Ramsey, supra note 2, at 160-81 (1978).

A final, but important, rejoinder to the "patient autonomy" or "right of privacy" rubric is that, in most cases, it is not the patient making the purportedly autonomous decision to refuse treatment, but a guardian or family member acting in the incompetent patient's stead.

Cloaking a determination based on social expediency under a privacy rationale in order to de-emphasize the difficult legal and moral issues involved, Quinlan suggested that its holding reflected the desires of the patient when, in fact, it reflected the wishes of others. While social expediency may have been a valid ground for the decision, the court should have dealt with the issue and its attendant problems straight-forwardly.


\textsuperscript{13} Horan & Grant, \textit{Prolonging Life and Withdrawing Treatment: Legal Issues}, 50 Littac: Q. 153, 166-68 (1983).

For the incompetent patient, the consensus seems to be that medical treatment may be terminated by a physician when, in his medical judgment, treatment is useless, which is to say that it offers no medically reasonable hope of benefit. In that situation, treatment such as mechanical respiratory assistance may be terminated and the patient allowed to die as the natural consequence of the underlying disease process. \textellipsis This does not mean that ordinary means of life support, such as food and drink, can be discontinued merely because the ultimate prognosis is hopeless.

\textit{Id.} at 166-67.

Another statement of consensus on these issues is found in the \textit{REPORT OF THE PRESIDENT'S COMMISSION}, supra note 7, at 2-6.

\textsuperscript{14} Id. at 16-19.

\textsuperscript{15} In \textit{re} Weber v. Stony Brook Hosp., 60 N.Y.2d 208, 456 N.E.2d 1186 (1983), the New York Court of Appeals rejected the petition of a court-appointed guardian ad litem for an infant born with myelomeningocele (spina bifida) requesting that corrective surgery be performed upon the infant. The infant's parents, who had retained custody, refused to consent to the surgery. The court of appeals thus affirmed an appellate division ruling overturning the decision of a trial court judge that the surgery be performed.\textsuperscript{16}

\textsuperscript{16} This article will focus on current judicial developments on the second of these questions, analyzing recent decisions on the withdrawal of nourishment from appellate courts in New Jersey and California. In New Jersey, the contours of the \textit{Quinlan} doctrine have been tested and refined in the case of \textit{In re Conroy},\textsuperscript{17} where an appellate division panel reversed a trial judge's ruling that would have allowed removal of a nasogastric feeding tube from a semi-comatose, elderly patient, even though the patient would have died a painful death of starvation and dehydration as a result. \textit{The appellate division's ruling in Conroy has been appealed to, and is pending before, the New Jersey Supreme Court.}\textsuperscript{18} Similar questions are presented in \textit{Barber v. California},\textsuperscript{19} where an appellate court dismissed homicide charges brought against two physicians for removing an unconscious patient from a respirator and, when the patient did not die as a result, removing the patient's intravenous feeding tube. The patient died within six days of starvation and dehydration.\textsuperscript{20}

If a consensus regarding the legal standards for withdrawal of lifesaving treatment is to be preserved, courts must write opinions which both respect the authority of physicians to make medical judgments, and the duty of society to make certain that the rights of patients are being protected through sound and ethical medical practice.\textsuperscript{21}

Subsequent to the court of appeals decision, the federal government filed suit against the hospital in the case to obtain the medical records of the infant, claiming that such records were necessary to complete an investigation into determining whether the infant's civil rights had been violated. The government's request was made pursuant to federal regulations on the care of handicapped infants, and 504 of the Handicapped Rehabilitation Act of 1973. See discussion in note \textsuperscript{6}, supra. The district court denied the request for records, on grounds that the state court proceedings had offered sufficient evidence to rebut any contention that the infant had been discriminated against. United States v. University Hosp., 575 F.Supp. 607 (E.D.N.Y. 1983), aff'd, 729 F.2d 144 (2d Cir. 1984).


\textsuperscript{20} As of publication date, this matter remained pending before the New Jersey Supreme Court.


\textsuperscript{22} Steinbeck, \textit{The Removal of Mr. Herbert's Feeding Tube}, HASTINGS CENTER REP., OCT., 1983, at 13.

\textsuperscript{23} See generally R. BURG, supra note 12, at 155-77; P. RAMSEY, supra note 2, at 154.
government regulation that medicine cannot operate in a vacuum of legal privacy. Striking a balance between the independence of physicians and the rights of patients is often difficult, but this is the task courts and legislatures must perform. The authors hope to demonstrate in this article that the California court in Barber has largely failed in this task, but fortunately, the New Jersey court in Conroy has succeeded in writing an opinion that should serve as a model for analysis of the issue of withdrawing nourishment.

Conroy, unlike Barber, explicitly acknowledges the dangers inherent in granting any person, even a close family member, the authority to direct the withdrawal of lifesaving treatment from an incompetent patient. Hence, Conroy rules that the benefit of the doubt must be in favor of continued treatment unless there is a certain diagnosis that the patient is either permanently comatose or imminently dying from a specified condition. Neither standard was honored by the physicians in the Barber case, who asked for permission to withdraw the respirator less than seventy-two hours after the patient first lapsed into unconsciousness, and then sought to withdraw the IV tube less than forty-eight hours later. The truly dangerous precedential impact of the Barber case comes not from its exonerating of these physicians from criminal liability, but from the imprimatur it granted to their actions which seriously compromised the rights of the patient. Barber, therefore, departs sharply from legal precedent on treatment of incompetent patients, while Conroy, with its solicitude for the rights of such patients, reinforces some of the most essential elements of the medico-legal consensus.

At the root of the divergence between Barber and Conroy is the question of whether intravenous and nasogastric feeding constitutes medical treatment, or is more akin to normal feeding. The former view, adopted by the Barber court, equates “mechanical nutrition” with treatments such as mechanical ventilator or respirator therapy and hemodialysis. As such, feeding can be withdrawn under the same criteria as any of these other treatments. The latter view, espoused by Conroy, states that a feeding tube is a simple part of routine nursing care, and does not constitute medical treatment. Although the ethical literature is divided on this subject, it seems clear that the law should not consider feeding by intravenous or nasogastric means to be equivalent to life-prolonging medical regimens such as ventilators. Our thesis throughout this essay is that nutrition rarely if ever constitutes a burden to the patient approximating that of more sophisticated medical treatments. Although there may be a set of narrowly defined situations where law and ethics may countenance the withdrawal of nourishment, neither Clarence Herbert nor Claire Conroy would properly be included in that category.

I. PEOPLE V. BARBER AND NEJDL—MISCARRIAGE OF PATIENTS’ RIGHTS?

The opinion of California’s Second Appellate Division Court of Appeals in Barber v. Superior Court is perhaps the most noteworthy development in the law governing withdrawal of medical treatment since the Quinlan decision of 1976. Barber is the first recorded instance of a homicide prosecution brought against physicians for death resulting from the withdrawal of life-support systems. Even more significant is the court’s holding that nutrition by intravenous or nasogastric means of a patient judged to be comatose, but not dying, is a non-obligatory form of medical treatment that may be withdrawn as a matter of medical judgment. Of further importance are the court’s rulings that physicians need not seek prior approval from a court or institutional ethics committee in order to carry out such a decision, and that physicians need not consult with a court-appointed guardian of the incompetent patient in

23 Drs. Duff and Campbell, in their well-known presentation on treatment of infants at the special-care nursery of Yale-New Haven Hospital, advocated autonomy for physicians and parents in deciding whether infants with conditions such as Down Syndrome and spina bifida should be treated aggressively, or permitted to die without treatment. “If working out these dilemmas in ways such as those we suggest is in violation of the law, we believe the law should be changed.” Duff & Campbell, Moral and Ethical Dilemmas in the Special-Care Nursery, 289 New Eng. J. Med. 890, 894 (1973).
24 See text accompanying notes 166–83, infra.
25 See id. at notes 184–202, infra.
26 464 A.2d at 310.
27 See text accompanying notes 161–64, infra.
28 See id. at notes 45–56, infra.
29 See id. at notes 73–91, infra.
30 195 Cal. Rptr. at 490.
31 464 A.2d at 311.
32 See id. at 330–11.
33 See text accompanying notes 136–51, infra.
34 See 464 A.2d at 311.
35 195 Cal. Rptr. at 488. See also REPORT OF THE PRESIDENT’S COMMISSION, supra note 7, at 32–39.
36 195 Cal. Rptr. at 490–91.
37 Id. at 493.
question.\(^3^8\) The acquiescence of close family members in the decision to discontinue treatment is deemed sufficient.\(^3^9\)

To some extent, these holdings fit into the accepted legal framework, under which treatment decisions remain the province of physicians and families.\(^4^0\) A crucial corollary of this framework, however, is that the conduct of physicians and families remain under the guidance of civil and criminal law.\(^4^1\) In absolving the physicians in this case of the homicide charges on the grounds that there is no duty to continue intravenous feeding of an incompetent patient,\(^4^2\) the California court may have initiated an inexorable decline of the capacity of the civil or the criminal law to set standards of conduct in withdrawing life-preserving treatment.\(^4^3\)

\(^3^8\) Id. at 492-93.
\(^3^9\) Id. at 493-94.
\(^4^0\) Courts have split on the question of whether judicial authority is a prerequisite to permitting the withdrawal of life-preserving treatment. Compare In re Quinlan, 355 A 2d at 663, with Superintendent v. Saksiewicz, 370 N.E. 2d at 434. However, even in Massachusetts, an appellate court has ruled that entry of a Do Not Resuscitate order is a decision that can be made by physicians and family without prior judicial approval. In re Dinnerstein, 380 N.E. 2d 134, 138-39 (Mass. App. 1978).
\(^4^1\) In re Storar, 52 N.Y. 2d 1908, 438 N.Y.S. 2d 266, 275, 420 N.E. 2d 64 (1981).
\(^4^2\) 195 Cal. Rptr. at 490.
\(^4^3\) Much of the commentary about Barber has focused criticism upon the decision to prosecute the physicians for homicide, and has thus missed the salient fact that in dismissing homicide charges, the court also held that there were no grounds for civil liability in the removal of Mr. Herbert's feeding tube. See text accompanying notes 71-76, infra. Yet, the commentaries express varying degrees of reservation concerning the propriety of the medical judgments in this case. In an article written prior to the appellate court ruling, one ethicist wrote:

"[The] removal of Mr. Herbert from the respirator only three days after he became comatose, and the removal of the feeding tube only two days after he began spontaneously to breathe on his own, does seem premature. However, it is one thing to fault doctors for their medical judgment, quite another to convict them of murder. A murder conviction would require the State to prove that Drs. Barber and Nejdil knew, or were indifferent as to whether, the coma was irreversible, and took Mr. Herbert off life-support apparatus anyway, aware that this would certainly cause his death. Steinbock, supra note 21, at 16."

It is not altogether clear why a diagnosis of irreversible coma would exonerate physicians from murder charges in all circumstances where life-support is withdrawn. For instance, if the physician's motive in withdrawing a respirator or feeding tube were clearly malicious—to cover up acts of malpractice, or to assist in a conspiracy to cause death for pecuniary motives, a prosecution would seem appropriate. Indeed, such were the suspicions of the Los Angeles County prosecutors who alleged that the motive for withdrawal of the respirator and feeding tubes was the desire to cover up possible malpractice in an understaffed hospital recovery room. Granelli, L.A. Case: Medical Act or Murder, Nat'l J.L., Feb. 21, 1983, at 5. Reverend John Paris, S.J., an ethicist who testified for two days on behalf of the defendants, stated that even if the doctors were trying to cover up malpractice, the decision to withdraw all life support, including feeding, "was a proper one once Mr. Herbert's brain was so destroyed that no recovery was possible." Id. Another commentator on the case, also a Roman Catholic priest, disagrees:

While the facts of this case may not have warranted prosecution for first-degree murder, they almost certainly did not warrant the issuance of a carte blanche to write orders discontinuing nourishment.\(^4^4\)

A. The Treatment of Clarence Herbert

The case against Dr. Nejdil, a surgeon, and Dr. Barber, an internist, arose out of their treatment of Clarence Herbert, a fifty-five-year-old patient admitted by Dr. Barber to Kaiser Hospital in August, 1982 for surgery to repair an ileostomy.\(^4^5\) The operation, performed by Dr. Nejdil, on the second postoperative day, led to the death of Dr. Nejdil.\(^4^6\)

The appeals court decision in the Herbert case is quite important for two reasons. First, it could very well establish, at least in California, a standard of practice that would allow physicians to remove nutrition and fluids from patients who are unconscious. Second, before this opinion, prosecutors could intervene in cases where food and water were withdrawn from patients under the assumption that an act of this nature could only be done with a malicious intent. But the holding of the court that the removal of fluids and nutrition from a patient who was only unconscious was allowable effectively prohibits prosecutors from intervening under the assumption that this act was done maliciously.

Barry, Euthanasia and the Church, Catholicism in Crisis, Feb., 1984, at 10.

At the very least, the court's holding that there was no duty whatever to continue the feeding of Mr. Herbert established a rule of civil law that would prevent the establishment of a standard such as that advanced by Professor Steinbock, one that requires careful and timely deliberation prior to the removal of life-support systems. If there were no duty to feed Mr. Herbert within days of his lapse into coma, then there clearly can be no duty to observe a waiting period prior to the withdrawal of a respirator. Furthermore, the court's seeming haste to absolve Drs. Barber and Nejdil of criminal charges led to a short-circuiting of the analysis called for in a case of this type by the civil law regarding withdrawal of medical treatment. See notes 77-88 and accompanying text. infra.

\(^4^4\) There is nothing in the Barber opinion to refute the conclusion that such a "carte blanche" has been provided to physicians treating patients in the early stages of coma or unconsciousness. While a sizeable body of ethical opinion believes that nutrition may be withheld from limited classes of patients, including, under certain circumstances, those who are permanently comatose, this literature does not support such a precipitous withdrawal of treatment. See Steinbock, supra note 21, at 16; Lynn & Childress, Most Patients Always Be Given Food and Water? Hastings Centr. Rep., Oct., 1983, at 17-19. Perhaps more disturbing is the court's failure to address the natural reservations to a policy permitting starvation of patients, such as those which have been articulated even by ethicists who favor withdrawal of nourishment in limited cases. As Daniel Callahan writes:

"The feeding of the hungry, whether they are poor or because they are physically unable to feed themselves, is the most fundamental of all human relationships. It is the perfect symbol of the fact that human life is inescapably social and communal. We cannot live at all unless others are prepared to give us food and water when we need them. If the duty of parents toward infants provides a perfect example of inescapable moral obligation, the giving of nourishment is its first and most basic manifestation. It is a most dangerous business to tamper with, or adulterate, so enduring and central a moral emotion, one in which the repugnance against starving people to death should be, on occasion, greater than that which a more strained rationality would call for."


\(^4^5\) Steinbock, supra note 21, at 13.
was successful, but shortly afterward, in the recovery room, Mr. Herbert suffered respiratory-cardiac arrest.46 Before he was revived and placed on life-support systems, Mr. Herbert had suffered severe anoxia with resultant brain damage.47 Exactly what transpired over the following several days is extremely unclear from the opinion, and must be gleaned from other sources, primarily the voluminous testimony presented at the preliminary hearing.48 On August 28, two days after the surgery and cardiac arrest, Dr. Nejdl and Dr. Barber reported to Mrs. Herbert that her husband was “clinically dead” and “brain dead.”49 After this communication from the physicians, Mrs. Herbert convened with her family and executed a written request, signed by Mrs. Herbert and the eight Herbert children, that all life-support machines be removed from Mr. Herbert.50 Despite the fact that Mr. Herbert had himself designated his sister-in-law, not his wife, to make decisions in the event of his incompetency,51 Dr. Nejdl and Dr. Barber caused this request to be carried out. However, Mr. Herbert continued to breathe without respiratory assistance, and maintained a normal pulse rate.52 On August 30, two days later, Dr. Barber and Dr. Nejdl reportedly approached the family and suggested that all life-support measures, including food and hydration which Mr. Herbert was receiving intravenously, be removed.53 However, Mrs. Herbert testified that she could not recall if doctors sought specific permission to withdraw the feeding.54 The intravenous tube was removed that day, just four days after the original cardiac arrest, and Mr. Herbert died on September 6, probably of dehydration.55 The official cause of death listed on the death certificate was diffuse encephalomalacia, secondary to anoxia.56

B. The Prosecution

An investigation by the Los Angeles County District Attorney led to the issuance of a criminal complaint for murder against Drs. Barber and Nejdl. The preliminary hearing on the matter was unusually extensive, including testimony from family members, physicians (but not the defendants), as well as two days of testimony from a prominent medical ethicist testifying in support of the defendants’ contention that withdrawal of nutrition in the circumstances of this case was a sound and ethical medical judgment.57 The magistrate concluded that the complaint should be dismissed on three grounds: (1) that the physicians did not “kill” Herbert, since the proximate cause of death was not their conduct, but the diffuse encephalomalacia, as listed on the death certificate; (2) that the physicians’ conduct under the circumstances was not unlawful, since it was the result of “good faith, ethical and sound medical judgment”; and, (3) that the physicians’ state of mind did not amount to malice.58 However, a superior court judge reinstated the complaint, concluding, despite the evidence that the physicians’ actions were well-motivated, and were ethical and sound in the eyes of the medical profession, that they constituted an intentional shortening of Mr. Herbert’s life that was neither justifiable nor excusable, and thus, murder.59

The court of appeals let stand the lower court’s conclusions regarding the inapplicability of the theories of justifiable or accidental homicide to the case of Mr. Herbert, but it deemed these theories irrelevant.60 Such traditional concepts of mitigating responsibility for the death of another, the court noted, evolved and were codified well before the development of “modern medical technology which is involved here, which technology

46 Id.
47 Id.
48 The preliminary hearing in the case against Drs. Barber and Nejdl resulted in dismissal of the homicide charges by Municipal Court Judge Brian Crahan. Id.
49 Id. Despite the testimony from Patsy Herbert that she was told her husband was clinically dead, the court of appeals wrote of this incident: “While there is some dispute as to the precise terminology used by the doctor, it is clear that they communicated to the family that the prognosis for recovery was extremely poor.” 195 Cal. Rptr. at 486.
50 Id.
51 Id.
52 Steinbock, supra note 21, at 13.
53 Id.
54 Id.
55 Granelli, supra note 43, at 5.
56 195 Cal. Rptr. at 487.
57 John J. Paris, S.J., was a consultant to the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.
58 Steinbock, supra note 21, at 13-14.
59 Judge Wenke [the judge who reinstated the criminal charges] ruled that California law does not allow anyone to shorten another’s life unless the latter’s condition is irreversible, and that [the hearing magistrate] failed to find that Mr. Herbert’s condition was irreversible when he was removed from the respirator and had the IV tubes withdrawn. Id. at 15. The question of the certainty of the physician’s diagnosis of Mr. Herbert’s comatose state is at the core of the legal and ethical issues posed by this case. See text accompanying notes 173-83, infra.
60 195 Cal. Rptr. at 490. By addressing this question only in the context of the duty owed to a permanently comatose patient, the appellate court skirted the central issue cited by Judge Wenke in reinstating criminal charges. Note 59, supra.
has caused our society to rethink its concepts of what constitutes ‘life’ and ‘death.’”61 This has resulted in a situation where “physicians and families ... are called upon to make intensely painful and personal decisions ... without clearly defined legal guidelines.”62 Even the California legislature’s response to these developments, the Natural Death Act (NDA), was deemed by the court to have little utility in resolving such dilemmas. Under the NDA, as under comparable “living will” statutes, competent persons may execute a prescribed form of treatment directive with the intent that such directive will guide family and physicians in the event of incompetency.63 The NDA offers insufficient relief and guidance to decisionmaking, the court concluded, because it “functions as intended for only a very limited number of patients.”64 Compounding the human reluctance to execute such directives, the court found, are the procedural requirements of the NDA, which “are so cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desires.”65 Notwithstanding these practical considerations, the court noted that the NDA by its own terms “does not purport to be the exclusive means by which such decisions can be made,” and “does not represent the exclusive basis for terminating life-support equipment in this state. Nor is a diagnosis of ‘brain dead’ a condition precedent to the cessation of such treatment.”66

Having determined that resolution of this case was not bound by the traditional standards of mitigated homicide or the relatively contemporary edicts of the NDA, the court decided that the dispositive legal principle was the physicians’ duty to act. The cessation of “heroic” life support measures, the court said, is not to be viewed for purposes of the criminal law as an affirmative act, but rather, as an omission.67 Since each pulsation of a respirator or each drip of intravenous fluid is comparable to a manually-administered injection or medicine, the court reasoned, disconnection of the mechanical devices providing these treatments “is comparable to withholding the manually administered injection or medication.”68 Disposing of the most controversial aspect of this case in prompt fashion, the court stated that the use of intravenous feeding “is the same as the use of the respirator or other form of life support equipment.”69 Any distinction between mechanical respirators and feeding devices, the court added,

seems to be based more on the emotional symbolism of providing food and water to those incapable of providing for themselves rather than on any rational difference in cases such as the one at bench. . . . Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration. Their benefits and burdens ought to be evaluated in the same manner as other medical procedure.”

According to the court, therefore, disconnection of the respirator and the intravenous tube were ethically equivalent omissions or failures to act, and consequently, the charges against Dr. Barber and Dr. Nejdl had to be analyzed according to the maxim that no criminal liability attaches for a failure to act unless there is a legal duty to act. 71 “Thus the critical issue becomes one of determining the duties owed by a physician to a patient who has been reliably diagnosed as in a comatose state from which any meaningful recovery of cognitive brain function is exceedingly unlikely.”

The answer to this question, apparent from the final disposition by the court, is that there is no duty to use a respirator, intravenous or nasogastric nutrition, or other forms of life-support on such a patient.72 The reasoning which leads to such a conclusion, however, remains elusive in

61 195 Cal. Rptr. at 487-88.
62 Id. at 488.
63 Id. at 489. See CAL. HEALTH & SAFETY CODE §7185 et seq. The court commented:
In adopting the Natural Death Act . . . the Legislature has gone part-way, but only part-way, in dealing with this troublesome issue. The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will too often go unused by those who might desire it. 195 Cal. Rptr. at 489.
64 Id. The President’s Commission has voiced much the same criticism. See REPORT OF THE PRESIDENT’S COMMISSION, supra note 7, at 143.
65 195 Cal. Rptr. at 489. The authors share many of the court’s reservations concerning the utility of living wills, Horan & Grant, supra note 13, at 166, but with some crucial additions. Death legislation should be effective only in truly terminal cases; it must not allow the withdrawal of basic nourishment or sustenance or of ordinary means which are beneficial; it must ensure that consent was given voluntarily to any “living will” or other consent form; it must prohibit mercy killing and assisted suicide; and it must not seek mandatory control over a physician’s judgment in some future undeterminable circumstance.
66 195 Cal. Rptr. at 489.
67 Id. at 490.
68 Id.
69 Id.
70 Id. For a contrary view, see Conroy, 464 A.2d at 311.
71 195 Cal. Rptr. at 490.
72 Id.
73 Id. at 494.
the preceding text of the opinion. The court relies primarily on three paradigms of analysis: that life-sustaining technology merely sustains biological functions in order to provide time for other processes to address the underlying pathology;⑨ that there is no duty to continue “useless” treatment, defined as that which cannot and does not improve the prognosis for recovery;⑩ and, that proposed treatment should be evaluated to determine whether it is proportionate or disproportionate in terms of the benefits gained versus the burdens caused.⑾ While each paradigm holds considerable merit, none is useful unless applied in a rigorous and thoughtful manner to the facts of a particular case. Proper application of the paradigms in this case would raise serious questions concerning the propriety of the physicians’ course of action, particularly the withdrawal of the intravenous tube.

The first paradigm—that “life-sustaining technology” is that which buys time for other procedures to combat the underlying pathology—certainly would not justify the timing of the decision to withdraw treatments from Mr. Herbert. The first decision to seek permission of the family for withdrawal of the respirator was made approximately thirty-six hours after the initial arrest.⑿ While it was evident even during these first days that Mr. Herbert had suffered severe anoxic trauma, the consulting neurologist on the case did not report Mr. Herbert’s prognosis for recovery as “nil” until September 4, that is, four days after all nutrition and hydration of Mr. Herbert had ceased.⑽ Prior to that, on August 29, the same neurologist had reported a “poor” prognosis for Mr. Herbert. While there was not a strong expectation of recovery to normal functioning in the earlier diagnosis, the small possibility that did exist was voided by the cessation of food and water.⑾ Continuance of this therapy offered Mr. Herbert his only chance that natural healing processes might restore him to some level of cognitive function. Since expert testimony indicated that either full or impaired recovery occurs in approximately 25 percent of patients rendered unconscious by trauma,⑿ the hopes for some recovery were not, as the court of appeals characterized them, “miniscule.”⑾ In any event, the record does not support a finding of sufficient medical certainty that would justify the withdrawal of nutrition a mere five days after the onset of unconsciousness.

Application of the second paradigm—that of proportionality—follows along similar lines. In this case, it was probably too early to determine whether respiratory therapy or intravenous feeding were useless. Unrefuted testimony had established that there was uncertainty regarding Mr. Herbert’s condition: Drs. Barber and Nejdl reported to the patient’s wife that he was “brain dead” and “clinically dead,” while the neurologist clearly considered Mr. Herbert alive, albeit with a poor prognosis.⑽ Clearly, if Mr. Herbert had been “brain dead” at that point, any further treatment would have been useless.⑾ However, if he were among that class of comatose patients with a small but significant chance of total or slightly impaired recovery, hydration and nutrition therapy would not have been useless. Again, insufficient time was available for such judgments once the intravenous tube was withdrawn.

The court’s failure to develop the third paradigm—that of proportionality—is most disappointing because this theme is essential to understanding the distinctions between mechanical respirators, intravenous feeding, and other forms of life-preserving therapy. As stated by the court, “proportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment.”⑾ Because the benefits and burdens attendant to each individual form of treatment will vary, it is thus essential, under this paradigm, to evaluate each mode of lifesaving therapy independently to determine if

⑨ Id. at 491.
⑩ Id.
⑾ Id.
⑿ Mr. Herbert was operated upon on August 26, 1981. Dr. Barber approached the family to seek removal of the respirator on the morning of August 28, 1981. Steinbock, supra note 21, at 13.
⑽ Barry, supra note 43, at 12.
⑾ Id. at 11. The testimony at the preliminary hearing, both from physicians who treated Mr. Herbert, and outside experts, revealed a wide range of opinion as to Mr. Herbert’s prognosis for recovery. A neurologist testifying for the defense stated that a patient who has suffered anoxia due to cardiac arrest has “no chance of ever recovering cerebral function.” Steinbock, supra note 43, at 15. But see Report of the President’s Commission, supra note 7, at 179 (“hypoxic . . . damage to the brain often initially causes loss of function in areas of the brain that might recover with time and treatment”). Another defense expert corroborated the opinion that recovery was impossible, stating that only “vegetative” functions, movement, would have remained. A prosecution expert, however, testified that Mr. Herbert had a “good chance” of recovery to some degree, but that it could not be predicted how much brain damage would persist. Studies relied upon by the prosecution showed that patients in Mr. Herbert’s condition have approximately a 10% chance of full recovery, and that 57% of such patients die within a month of the anoxic insult. Steinbock, supra note 21, at 15; Barry, supra note 43, at 12. Therefore, if Mr. Herbert had survived a month without the respirator, he would then have had a 20-25% chance of full recovery.
⑿ Id.
⑽ 195 Cal. Rptr. at 492.
⑾ Steinbock, supra note 21, at 13.
⑿ See note 79, supra.
⑾ 195 Cal. Rptr. at 491.
the principle of proportionality justifies its use. Under such analysis, continued use of a heart-lung device, cardio-pulmonary resuscitation, or a mechanical ventilator upon a patient who, notwithstanding the use of such treatment, is imminently dying, may be seen as disproportionate. The evaluation changes somewhat where the patient is not imminently dying, but is diagnosed as permanently comatose. If sufficient time has passed for a long-term prognosis to be made, and that prognosis is nil, the burden of the bodily intrusion and other specific aspects of the therapy should be weighed against the benefit of continued treatment. Since the judgment of "proportionality" is one belonging to the patient, application of this paradigm is particularly difficult in this situation where the patient cannot communicate. No single authority—physician, family, or guardian—should be given unfettered freedom in making this choice, and care should be taken to protect the patient's interest in receiving treatment from being infringed in order to alleviate the alleged burdens which the patient's existence is placing upon others.

These principles make it particularly difficult to justify withdrawal of nourishment and hydration in the offhand manner of the Barber opinion. As compared to ventilator therapy, dialysis or chemotherapy, intravenous and nasogastric feeding are generally less intrusive and burdensome. Feeding by intravenous means is closely aligned with
decisionmakers in refusing life-preserving treatment should be exercised only to protect the patient from treatment that is unduly burdensome. The proxy's authority does not extend to determinations that the continued life of the patient has become too much of a burden upon a spouse or family. See note 86, supra. The REPORT OF THE PRESIDENT'S COMMISSION, supra note 7, in discussing the two bases for proxy decisionmaking, reflects this view. Under the substituted judgment principle, to be applied only if the patient were at one time capable of expressing views on the matter at hand, "the patient's own definition of 'well-being' is respected," id. at 132-33. Thus, the patient's own expressed wishes on a preferred course of treatment may be honored. This principle was applied by the New York Court of Appeals in the case of Brother Joseph Fox. See In re Storar, 52 N.Y.2d 1008, 438 N.Y.S.2d 266, 420 N.E.2d 64 (1981).

The second basis for proxy judgments, the so-called "best interests" standard, requires that the choice for the patient be premised on "what is in that patient's best interests by reference to more objective, socially shared criteria. Thus, the best interest standard [rests] ... solely on protection of the patient's welfare." REPORT OF THE PRESIDENT'S COMMISSION, supra note 7, at 134-35 (footnotes omitted). The Commission would permit consideration of the "impact of the decision on an incapacitated patient's loved ones" only if "especially stringent standards of evidence" are met showing that the patient would disregard personal interests in order to avoid creating burdens upon such persons. Id. at 135-36.

In its concluding recommendations on this topic, however, the President's Commission adopts the position that the course of treatment chosen be that which will "promote the patient's well-being as it would probably be conceived by a reasonable person in the patient's circumstances." Id. This rather open-ended standard is further muddled by the assertion that where no consensus exists, surrogates "retain discretion to choose among a range of acceptable choices." Id. Under certain circumstances, this standard leaves surrogate decisionmakers with an unacceptable level of discretion that seems to defeat the principles behind the best interests standard. In Barber, for example, the course of the surrogates to direct the withdrawal of the respirator was made at the suggestion of physicians who misinformed the family as to the gravity of the patient's condition, effectively stating that the patient was already dead. See notes 49-51 and accompanying text, supra. Furthermore, given the element of time and the unknown possibilities for the patient's recovery, any assertion that the subsequent withdrawal of nourishment was in the patient's best interests is surely questionable. See n79, supra.

The Barber court rejected both the substituted judgment and best interests principles, but did not state which of the two it was relying upon to ratify the decision to withdraw treatment. 195 Cal. Rptr. at 493. The court noted evidence that Mr. Herbert had expressed a desire not to "become another Karen Quinlan," id., but as a matter of medical prognosis, it was less than certain that he was in such a permanent vegetative coma. Moreover, there was no evidence that Mr. Herbert had expressed an intention that he be deprived of all food and water under such circumstances. In fact, his only undisputed statement of intention, that his sister-in-law be consulted in the event of his incapacity to make medical decisions, was turned aside by the court's assertion, sua sponte, that "his wife and children were the most obviously appropriate surrogates in this case." Id. at n.2. The court also relied upon the Presidential Commission's statement that the impact upon the family may be considered in making treatment decisions, but neglected the crucial caveat of the Commission that "stringent standards of evidence should be required" to prove that the patient would relinquish self-interest in such a case. Compare id. at 493 with REPORT OF THE PRESIDENT'S COMMISSION, supra note 7, at 136.
catheterization and other forms of non-heroic, supportive care.89 More importantly, the manner of death that results from dehydration and starvation is a burden which must be taken into account under the "proportionality" paradigm. Although the exact clinical symptoms will vary, they include soreness and burning of the lips, lacrimation, lesions and large fissures on the lips, ulcerations, crusting, and dermatitis on the skin, hard sebaceous plugs on the nose, fissures on the tongue, and swelling associated with edema.90 Assuming Mr. Herbert incurred some of these symptoms prior to his death, even if he was unaware of them, it is difficult to square that reality with the court's assertion that he received "care which preserved his dignity and provided a clean and hygienic environment."91

II. MATTER OF CONROY: AN ESSENTIAL COROLLARY TO QUINLAN

The California appellate court in Barber quite clearly considered its decision regarding the licitness of withdrawing intravenous nutrition to be in accord with the doctrines set forth in Quinlan.92 It is ironic, then, that the Barber panel entirely ignored the opinion in Conroy, issued over three months earlier,93 in which an appellate panel from Quinlan's "home" jurisdiction expressly rejected an argument that Quinlan justified the withdrawal of a nasogastric feeding tube.94 Conroy thus reversed the ruling of a superior court judge that nutrition could be withdrawn from an elderly, semi-comatose nursing home resident.95 The appellate court found that such an action would constitute euthanasia, as well as clear violation of medical ethics.96 Because Ms. Conroy was not comatose—testimony indicated that while she had no cognitive or volitional functioning, she was capable of primitive responses to stimuli—97 the Conroy opinion reserved the question of whether mechanical nutrition can be withdrawn from a comatose patient under any circumstances.98 However, the panel made clear that if such circumstances exist, the patient from whom treatment is to be withdrawn must be "imminently dying."99 Hence, despite the factual differences between the two cases, it is clear that the New Jersey court would not have countenanced the treatment of Clarence Herbert by his surgeon and internist as a reasonable extension of the principles set forth in Quinlan.

A. The Setting: Medical and Legal

Clair C. Conroy was an eighty-four-year-old resident of the Parklane Nursing Home, Bloomfield, New Jersey, who suffered from "severe organic brain syndrome and a myriad of other physical problems."100 Principal among these problems was a gangrenous left leg, which caused Ms. Conroy's admission to the hospital in July, 1982.101 Although her physicians recommended amputation of the leg, Ms. Conroy's nephew, Thomas C. Whittemore, who had been appointed her legal guardian in 1979, refused permission for the surgery on grounds that it would be in his aunt's best interests.102 Physicians had prognosticated that without the surgery, Ms. Conroy would die within two weeks. However, she survived, and was discharged back to the nursing home in November, 1982.103 At the time of the initiation of court proceedings, the leg did not pose a present threat to Ms. Conroy's life, nor was it a source of major pain.104

With the passage of time, Ms. Conroy's condition of organic brain syndrome progressively worsened. She gradually lost the ability to walk, to reason, and to feed herself, although at the time of her admission to the hospital in 1982, she was able to respond to commands.105 During her hospital stay, in July 1982, Ms. Conroy's attending physician placed her on a nasogastric feeding tube because of her inability to swallow sufficient quantities of food and water.106 By early 1983, she was unable to move except for minor movements of the upper-body extremities. She

88 See In re Storar, 420 N.E.2d at 73.
90 195 Cal. Rptr. at 486.
91 Id. at 491-92.
92 The opinion in Conroy was issued July 7, 1983. The opinion in Barber was issued October 12, 1983.
93 464 A.2d at 310-11.
95 464 A.2d at 314-15.
96 For instance, Miss Conroy could sometimes follow people with her eyes, could scratch herself, and smiled and moaned when touched or stroked. Brief of Appellant, supra note 90, at 11.
97 464 A.2d at 312.
98 Id.
99 Id. at 304.
100 Id. at 304.
101 457 A.2d at 1233.
102 Id.
103 Id.
104 Id.
105 464 A.2d at 304.
106 Id.
gave mild response to touching and stroking, and was able to follow movement with her eyes.\textsuperscript{97} Ms. Conroy was not brain dead, comatose, nor in a chronic vegetative state.\textsuperscript{98}

After unsuccessfully requesting Ms. Conroy’s attending physician to remove the nasogastric feeding tube and allow his aunt to die, Mr. Whittemore filed a complaint in the Chancery Division of Superior Court for Essex County on January 24, 1983.\textsuperscript{99} After testimony on January 31 and February 1 from the guardian, Ms. Conroy’s physicians, the nursing home administrator, and a professor of ethics at a Roman Catholic seminary,\textsuperscript{100} the trial court issued an opinion on February 2 authorizing the guardian to direct that the feeding tube be removed.\textsuperscript{101} The decision was stayed pending appeal, but Ms. Conroy nevertheless expired two weeks after the trial court’s order.\textsuperscript{102}

The appellate court, as a first matter, rejected arguments that Ms. Conroy’s death had mooted the appeal, noting that the case afforded an opportunity to provide guidance to family members, guardians, physicians, and hospitals, “the need for which extends far beyond the facts of this case.”\textsuperscript{103} Additional impetus for reaching the merits of the appeal lay in the text of Judge Stanton’s opinion itself, which frankly acknowledged that Ms. Conroy would suffer a painful death by starvation,\textsuperscript{104} but concluded that withdrawal of nutrition was appropriate due to her diminished “intellectual capacity.”\textsuperscript{105} The trial court also recognized that its decision might have untoward consequences as a precedent upon the treatment of other handicapped and institutionalized patients.\textsuperscript{106} The appellate panel explicitly agreed with this assessment,\textsuperscript{107} and in the course of its opinion, emphasized that the law governing withdrawal of medical treatment must take account not only of the rights of individuals to refuse treatment, but also of the obligations of the medical profession and others to provide care.\textsuperscript{108} This latter idea is an essential corollary to the Quinlan doctrine of privacy, for it prevents that doctrine from being twisted to permit active or passive euthanasia.\textsuperscript{109}

The Conroy court applied the Quinlan doctrine to the case before it in two stages: first, the court considered whether the prognosis of Ms. Conroy was sufficiently grave as to render the state interest in preserving her life de minimis;\textsuperscript{110} second, the court queried whether the “bodily invasion” represented by the feeding tube was sufficiently great so as to increase the patient’s right to privacy to direct that the feeding tube be removed, or more precisely, to have her guardian direct that course for her.\textsuperscript{111} These two questions derive from the key language of Quinlan that “the State’s interest [in preservation of life] weakens and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately, there comes a point at which the individual’s rights overcome the State interest.”\textsuperscript{112} In the court’s view, this point had not been reached in the case of Ms. Conroy.

\textsuperscript{97} See note 97, supra.
\textsuperscript{98} 464 A.2d at 304-05.
\textsuperscript{99} 457 A.2d at 1234.
\textsuperscript{100} The priest, Rev. Joseph Kakura, testified in support of the removal of the feeding tube.
\textsuperscript{101} 188 N.J. Super. 523, 457 A.2d 1232 (1983).
\textsuperscript{102} 464 A.2d at 304.
\textsuperscript{103} Id. at 306.
\textsuperscript{104} 457 A.2d at 1236, 1237.
\textsuperscript{105} Id. at 1236. The trial court asserted that, under Quinlan, life-preserving treatment may be withdrawn by a surrogate “when intellectual functioning is reduced to a very primitive level or when pain has become unbearable or unrelievable.” Id. at 1234-35. In truth, the Quinlan standard makes no mention of “diminished intellectual capacity,” but is concerned primarily with medical prognosis. 355 A.2d at 664.
\textsuperscript{106} 457 A.2d at 1236. Judge Stanton expressed misgivings of two types. First, he said that when he first started thinking about removing the nasogastric tube, which he terms a “very simple device,” he “worried that [he] was getting perilously close to a straightforwardly wrongful refusal to feed a fellow human being.” Id. However, he concluded that feeding by nasogastric tube is different from failing to feed a patient who could take nourishment by herself or with assistance. “For one thing, I think that the permanent loss of the ability to swallow is often reflective of a vast impairment of brain functioning. For another, I think that nature may be telling us something about a patient when the ability to swallow is permanently lost.” Id.
\textsuperscript{107} Id. The judge’s other misgivings concerned the impact of this decision on other cases: I have also had some misgivings about an inappropriate impact that a decision such as the present one might have on the treatment of elderly senile persons or on the treatment of retarded persons of all ages. Sometimes people incorrectly evaluate the meaningfulness of the lives of the senile or the retarded. As viewed by some, a decision such as the present one might lead to a wrongful withholding of treatment for the senile or the retarded. Here I can only say that careful distinctions have to be made.
\textsuperscript{108} 464 A.2d at 310.
\textsuperscript{109} We are also troubled by the trial judge’s framing of the issue as whether the patient will return “to some meaningful level of intellectual functioning.” Put simply, to allow a physician or family member to discontinue life-sustaining treatment to a person solely because that person’s lack of intellectual capacity precludes him from enjoying a meaningful quality of life would establish a dangerous precedent that logically could be extended far beyond the facts of the case now before us.
\textsuperscript{111} Id.
\textsuperscript{112} Id. at 313-14.
\textsuperscript{113} Id. at 315.
\textsuperscript{114} Id. at 308-10.
\textsuperscript{115} Id. at 310-12.
\textsuperscript{116} 355 A.2d at 664.
B. Inquiry One: The Extent of the State Interest in Preserving Life

In dealing with the first question, that of Ms. Conroy’s prognosis, the court emphasized the testimony which established that the patient was not comatose, nor in a permanent vegetative state, and that physicians could not tell when, or from what cause, she would die.\(^{123}\) These factors are critical to an understanding of the Conroy decision. There is little dispute that Ms. Conroy, in Judge Stanton’s words, was “desperately sick,” that her mental functioning was “primitive,” or that she had no expectation for recovery.\(^{124}\) However, as the appellate court noted, other cases in which the withdrawal of treatment such as respirators, dialysis, or cardio-pulmonary resuscitation has been authorized involved patients who were either in “an irreversibly comatose or incurably terminally ill” condition.\(^{125}\) Ms. Conroy’s prognosis, the court concluded, “supports a significantly greater state interest in continued treatment” than in cases such as Quinlan,\(^{126}\) Matter of Spring,\(^{127}\) and In re Severns.\(^{128}\) The court specifically distinguished Ms. Conroy’s condition from that of Karen Quinlan.

\(^{123}\) 464 A.2d at 304-05.
\(^{124}\) Id. at 305.
\(^{125}\) Id. at 309.
\(^{126}\) 355 A.2d 647 (N.J. 1976).
\(^{127}\) 405 N.E.2d 145 (Mass. 1980).
\(^{128}\) 421 A.2d 1334 (Del. 1980). The patients in each of these cases were in a prolonged, chronic, comatose state which had been diagnosed as irreversible. In Severns, upon remand, the Delaware chancery court issued an order granting the prospective guardian’s request, “to discontinue all medical supportive measures designed to keep Mrs. Severns alive in a comatose state, a request in which he is joined by all immediate members of the Severns family.” Severns v. Wilmington Medical Center, Inc., 425 A.2d 156, 160 (1980).

In other words, those having the care of Mrs. Severns are not to return her to a respirator in order to sustain her breathing, are not to administer antibiotic drugs in the event of a pulmonary infection or the like, and a feeding tube is not to be inserted in her trachea. Furthermore, a no code blue [Do Not Resuscitate] order is to be posted on her medical chart, and finally, no drugs or medicines are to be administered to Mrs. Severns other than those normally used to preserve bodily hygiene. Particularly for the prevention or cure of constipation or diarrhea.

Id. (Emphasis added.) Significantly, however, the court did not direct the removal of the nasogastric feeding tube which was then providing Mrs. Severns with a life-sustaining formula. Id. at 157. Indeed, the prospective guardian, Mrs. Severns’ husband, petitioned only that a feeding tube not be surgically placed in her trachea. Id. at 138. Although the distinction between these two forms of providing nourishment is a fine one, it seems defensible to differentiate between the passive means of supplying food through a nasogastric or IV tube, and the aggressive means of performing surgery to insert a tube when the body will no longer accept food through the more simple measures. The surgery itself may place burdens upon the person and dignity of the patient, burdens that, even though not felt by the patient, may justify refraining from that course of medical treatment.

\[^{129}\] The testimony] seems to describe a woman who, like an infant less than a year old, experienced and responded to her surroundings but lacked the intellectual capacity to understand most of them. By comparison, Karen Quinlan was unaware of her environment and had only the most reflexive reactions to outside stimuli: [quoting from the Quinlan opinion]

The further medical consensus was that Karen in addition to being comatose is in a chronic and persistent “vegetative” state, having no awareness of anything or anyone around her and existing at a primitive reflex level. Although she does have some brain stem function (ineffective for respiration) and has other reactions one normally associates with being alive, such as moving, reacting to light, sound and noxious stimuli, blinking her eyes, and the like, the quality of her feeling impulses is unknown. She grimaces, makes stereotyped cries and sounds and has chewing motions. Her blood pressure is normal. . . .

The distinction between an “awake” but confused patient like Conroy and an “asleep” vegetative patient like Karen Quinlan is material and is determinative in this case. The Quinlan Court held that the State’s interest in preserving a patient’s life depends on whether the patient ever will return to cognitive, sapient life. . . . Thus, it is plain that Quinlan applies only to noncognitive, vegetative patients. The Quinlan Court evidently was of the opinion that the State’s interest in preserving life outweighs the patient’s right to privacy when the patient retains the capacity to relate to the outside world. In the present case, Conroy was sapient, but lacked the intellectual capacity to understand what she observed. Under the principles of the Quinlan case, the State had a substantial and overriding interest in preserving her life.\(^{129}\)

In light of her death just twelve days after Judge Stanton issued his ruling, the appellate court may have chosen to give the benefit of doubt to those who considered Ms. Conroy to be irreversibly, terminally ill, and thus, in the same legal status as Karen Quinlan.\(^{130}\) However, the court deliberately rejected this course, and strongly implied that nothing less than a certain diagnosis of terminal illness and/or irreversible comatose or vegetative state is necessary to tip the scales in favor of the right to privacy and against the state interest in preserving life.\(^{131}\) Two concerns seem to have motivated the judges to adopt this course: first, the fact that under Quinlan, it is the guardian’s substituted judgment, and not that of the patient herself, that is decisive;\(^{132}\) and second, the trial court’s framing of

\(^{129}\) 464 A.2d at 309-10.
\(^{130}\) In our view, the right to terminate life-sustaining treatment based on a guardian’s substituted judgment should be limited to incurable and terminally-ill patients who are brain dead, irreversibly comatose or vegetative and who would gain no medical benefit from continued treatment.
\(^{131}\) Id. at 310.
\(^{132}\) Id.
the issue as whether the patient would ever return "to some meaningful level of intellectual functioning." 133

Put simply, to allow a physician or family member to discontinue life-sustaining treatment to a person solely because that person's lack of intellectual capacity precludes him from enjoying a meaningful quality of life would establish a dangerous precedent that logically could be extended far beyond the facts of the case now before us. In our view, the right to terminate life-sustaining treatment based on a guardian's substituted judgment should be limited to incurable and terminally ill patients who are brain dead, irreversibly comatose or vegetative, and who would gain no medical benefit from continued treatment. 134

The court concluded that "further extension" of Quinlan would hand over to physicians, family members, and judges the power to determine "whose quality of life is so slight that he should not be kept alive." 135

C. Inquiry Two: The "Burdensomeness" of Nourishment

The court more quickly disposed of the second inquiry under Quinlan, whether the degree of bodily invasion used by the treatment in question tips the balance in favor of the patient's right to have that treatment withdrawn. "[T]he patient's interest in privacy," the court stated, "is greater when his medical condition requires 24-hour care, dependence on machines to carry on bodily functions, or regular exposure and handling of his body." 136 Thus, courts which have adopted Quinlan have permitted the withdrawal of what the Conroy court termed "complex, highly intrusive treatments like respirators, hemodialysis, chemotherapy, or amputation." 137

But feeding tubes alone, according to Conroy, do not fit into the same categories of "intrusive" treatments. 138 In contrast to Karen Quinlan, the court noted, Clair Conroy "was in the less restrictive environment of a nursing home, was not subject to intensive nursing care, and had none of her bodily functions replaced by a machine." 139 In language which is likely to be a focal point for debate among medical ethicists, the court stated that:

The nasogastric tube was no more than a simple device which was part of Conroy's routine nursing care. It was not really "medically treatment" at all. In

truth, Conroy was little different from the many other ill, senile or mentally disabled persons who are bedridden and cared for in nursing homes. Consequently, the bodily invasion she suffered as the result of her treatment was small, and should not be held to outweigh the State's interest in preserving her life. 140

Citing a lack of precedent on the issue of whether nutritional "treatment" may be withdrawn, 141 the court turned to the Storar opinion of the New York Court of Appeals for guidance. 142 In Storar, the patient was a fifty-two-year-old retarded, lifelong resident of state institutions who was diagnosed as having terminal, incurable cancer of the bladder. 143 He required blood transfusions periodically to compensate for internal bleeding caused by his disease, and without the transfusions, he would have died within weeks. 144 In reversing a lower court which had ordered the blood transfusions discontinued at the request of the patient's mother, the New York court noted that the transfusions "were analogous to food—they would not cure the cancer, but they could eliminate the risk of death from another treatable cause." 145 Thus, the court found that it "should not in the circumstances of this case allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease." 146

The Conroy court found this reasoning to apply in the case of withdrawal of food and water from a patient. "Nourishment itself does not cure disease. Neither is it an artificial life-sustaining device. Rather, it is a basic necessity of life whose withdrawal causes death and whose provision permits life to continue until the patient dies of his illness or injury." 147 The court did not proscribe the withdrawal of nourishment in all circumstances; but did set forth a strict standard which would limit the withdrawal of nourishment to strictly-defined categories of patients.

Whether nourishment may ever be withdrawn from a patient whose medical condition is unlikely to improve is not the issue here. We hold only that when nutrition will continue the life of a patient who is neither comatose, brain dead nor vegetative, and whose death is not irreversibly imminent, its discontinuance

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133 Id. See note 117, supra.
134 464 A.2d at 310.
135 Id.
136 Id.
137 Id.
138 Id. at 311.
139 Id.
140 Id.
141 Id. The court did not take note of the final disposition of the Sevins case, see note 128, supra, which ordered that no surgery to insert a tracheal feeding tube be performed, but permitted the continuance of nasogastric feeding. 425 A.2d at 160.
143 420 N.E.2d at 69.
144 Id. at 70.
145 Id. at 73.
146 Id.
147 464 A.2d at 312.
cannot be permitted on the theory of the patient’s right to privacy or indeed any other basis.\textsuperscript{144}

The conjunctive in the second sentence emphasizes that the Conroy court has written a standard for withdrawal of nourishment that is more exacting than that demanded for withdrawal of more highly intrusive medical treatments. Courts have previously required a diagnosis of either persistent vegetative state (including coma) or terminal illness in such cases.\textsuperscript{145} However, where the “treatment” involves nourishment, according to Conroy, the class of patients from whom that treatment may be withdrawn is more limited. “The patients must be both comatose or vegetative,” and their death must be “irreversibly imminent.”\textsuperscript{150} This standard would not permit the withdrawal of nourishment either from patients in the condition of John Storar, who are terminally ill, but not imminently dying, or from patients in the condition of Karen Quinlan who are permanently comatose, but not imminently dying. Nor would this standard permit the withdrawal of nourishment from a patient such as Clarence Herbert, who was rendered “dying” only after the withdrawal of his nourishment.\textsuperscript{151}

D. Conroy and Quinlan: Some Observations

Some critics may charge that Conroy, by drawing a distinction between different forms of life-preserving “treatments,” contradicts the legal principles of Quinlan.\textsuperscript{152} Analysis of this position requires a clear understanding of what Quinlan actually held and stated. Quinlan is often read broadly as granting freedom to physicians, families, and institutions to make treatment decisions free of interference or regulation from the courts.\textsuperscript{153} This reading is understandable, given Quinlan’s lengthy discussions of numerous ethical positions supporting the withdrawal of treatment in certain cases,\textsuperscript{154} and more importantly, given Quinlan’s reliance on the constitutional right of privacy as the polestar of patients’ rights in such cases.\textsuperscript{155} It is the purpose of this constitutional right, fashioned in the context of abortion regulation,\textsuperscript{156} to erect a high and sturdy wall against governmental intrusion into the decisionmaking process.\textsuperscript{157}

In spite of the ethical dicta and the constitutional underpinnings, however, the actual order in Quinlan did not go so far as to give the proxy decisionmaker (Karen Quinlan’s father) the right to direct the course of his daughter’s treatment. Instead, the court only gave Mr. Quinlan the right to choose the physician responsible for making treatment decisions, and to consent to the withdrawal of the respirator if a physician made such a medical decision.\textsuperscript{158} Moreover, even if the “spirit” of Quinlan, and the constitutional jurisprudence on which it is based, support a system of familial and institutional autonomy in treatment decisions, the actual holding of Quinlan demands a strict balancing test between the constitutional right of privacy and the state interest in preserving life.\textsuperscript{159} This balancing test was meticulously applied by the appellate court in Conroy.\textsuperscript{160} Some critics may charge that Conroy was overly-solicitous in its protection of the state interest,\textsuperscript{161} and in retrospect, that opinion may be valid, given the death of the patient so shortly after the trial court issued its opinion. Yet, however valid that opinion might be, it does not resolve the issue which the appellate court considered to be at the heart of the state interest in this matter. If Quinlan were extended to permit the withdrawal of treatment from Miss Conroy, it might then be used to justify withdrawal of treatment from a large class of persons, not terminally-ill, and not permanently comatose, but who, nevertheless, are deemed to lack a potential for a “meaningful level of intellectual functioning.”\textsuperscript{162}

A major difficulty in addressing this issue of when a patient’s condition has deteriorated sufficiently to permit the withdrawal of life-preserving treatment is the uncertainty of medical diagnosis. For evidence of this problem, one need look no further than Quinlan, in which experts incorrectly surmised that the patient could not survive withdrawal from the respirator in any form,\textsuperscript{163} and Conroy, where the attending physicians

\textsuperscript{144} Id.
\textsuperscript{145} Id. at 310.
\textsuperscript{146} Id. at 312.
\textsuperscript{150} See notes 77-81 and accompanying text, supra.
\textsuperscript{152} See generally REPORT OF THE PRESIDENT’S COMMISSION, supra note 7, at 30-32.
\textsuperscript{153} 355 A.2d at 658-60.
\textsuperscript{154} See P. Ramsey, supra note 2, at 292-97.

\textsuperscript{156} Roe v. Wade, 410 U.S. 113 (1973).
\textsuperscript{158} 355 A.2d at 664.
\textsuperscript{159} Id.
\textsuperscript{160} See text accompanying notes 124-51, supra.
\textsuperscript{152} See note 152, supra.
\textsuperscript{161} 464 A.2d at 310.
\textsuperscript{153} 355 A.2d at 655.
could pinpoint no particular life-threatening condition two weeks before the death of the patient. No court can improve the precision of imperfect medical judgments. In Conroy, the appellate court reaffirmed that these imperfect medical judgments will be respected, but effectively held that where such judgments do not confirm a diagnosis of terminal illness or irreversible loss of all but vegetative brain function, the state interest in the patient’s life will not permit the withdrawal of life-preserving treatments. This standard of certainty ensures that the balancing test of Quinlan will be fairly met, and that in those situations where the precise condition of the patient may be in doubt, health care providers will err on the side of preserving life rather than withholding treatment. Under such a system, there is a risk that some patients may be over-treated, yet, an alternative standard may bring about the converse risk of under-treatment. By affirming the legitimacy of the state interest in preserving the life of Ms. Conroy, the New Jersey court has held that as a matter of public policy, law, and sound medical ethics, the right to continue receiving basic supportive care such as nourishment is at least as important as the right to refuse such treatment, and where the patient is incompetent, such care will continue to be provided as a matter of right.

By adopting such a stringent policy on withdrawal of nourishment, the New Jersey court has staked out a position which not only came to be at odds with the opinion issued in People v. Barber, but which is likely to be controversial in the eyes of some medical ethicists. If the somewhat ragged legal consensus on medical treatment questions is not to collapse entirely over the issue of nourishment, the contrary positions on these issues must be examined to determine, among other things, which side has better stated its case. The conclusion of this essay will evaluate the Conroy and Barber decisions from the standpoint of both legal and ethical reasoning to determine which articulated the more sound and justifiable rule of law around which a consensus on the issue of withdrawal of nourishment may be established.

III. A RULE OF LAW AND ETHICS FOR WITHDRAWAL OF NOURISHMENT

In a relatively short period of time, a crisis in medical ethics has arisen over the issue of withdrawing so-called “mechanical” forms of nourishment—predominantly intravenous and nasogastric feeding tubes—from seriously-ill patients. This crisis has arisen because of confusion over whether cessation of nourishment, as held by Conroy, constitutes euthanasia, or whether it is merely a permissible medical

164 See text accompanying notes 146-49, supra.
165 See Lynn & Childress, supra note 44, at 21.

166 464 A.2d at 315. The New Jersey court characterized the trial court opinion as authorizing “active euthanasia,” because, if the order had been carried out, “[Miss Conroy] would have been actively killed by independent means rather than allowed to die of existing illness or injury.” Id. This assessment comports with the condemnation of such practices contained in the Declaration on Euthanasia, issued in 1980 by the Sacred Congregation for the Doctrine of the Faith, in Vatican City, Reprinted in Report of the President’s Commission, supra note 7, at 300 et seq. The Declaration is relevant to the legal forum if only due to the fact that proponents of withdrawing treatment in the cases of Barber and Conroy assert that such actions are deemed ethically sound by the Roman Catholic Church. See Paris Testimony 1 (January 25, 1983), at 59-61, note 57 and accompanying text, supra; Kukura Testimony, at 16-18, note 110 and accompanying text, supra. Fathers Paris and Kukura asserted that further feeding of such patients is extraordinary and disproportionately burdensome treatment, “considering [the treatment’s] long term use and their inability to provide anything other than continued basic assistance for the patient.” Id. at 18. The basis for this opinion is the Declaration’s statement that:

It is . . . permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community.

Report of the President’s Commission, supra note 7, at 306. (Emphasis added.)

Yet, one cannot consider only this section of the Declaration, and ignore its more basic statements of principle condemning acts or omissions that are calculated to bring upon death. “Life is a gift of God, and on the other hand, death is unavoidable; it is necessary therefore that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity.” Id. (Emphasis added.) Elsewhere, the Declaration is more specific:

By euthanasia is understood an action or omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia’s terms of reference, therefore, are to be found in the intention of the will and in the methods used. It is necessary to state firmly once more that nothing and no one can in any way permit the killing of an innocent human being, whether a foetus [sic] or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying. Furthermore, no one is permitted to ask for this act of killing, either for himself or herself or for another person entrusted to his or her care, nor can he or she consent to it, either explicitly or implicitly. Nor can any authority legitimately recommend or permit such action.

Id. (Emphasis added.)

In the cases under discussion, it is evident that the California appellate court and the New Jersey trial court authorized actions which could be counted as euthanasia as that term is understood by the Declaration. Judge Stanton, speaking of Claire Conroy, wrote:

I am firmly convinced by the evidence in this case that Claire Conroy’s intellectual functioning has been permanently reduced to an extremely primitive level. She suffers from all of the medical problems mentioned above. The general state of her health is very poor and will remain so. Her life has become impossibly and permanently burdensome for
protocol, as viewed in Barber, akin to turning off a respirator or issuing a DNR order. It seems unlikely that this crisis will be allowed to persist, for differences of such magnitude on the fundamental question of whether patients may be allowed to die of starvation could have a nearly chaotic effect on day-to-day decisionmaking for those charged with caring for the seriously and chronically ill. Furthermore, as the price of medical treatment continues its prodigious rate of inflation, the rights of patients to certain basic standards of care ought to be articulated clearly and authoritatively. If this is not done, the pressure to cut costs—and remove treatment—may intrude excessively into medical treatment decisions, quietly sabotaging those rights in the process.

In the absence of a consensus on these issues from the realm of ethics, courts will be forced to select from among increasingly divergent viewpoints the standards which are to govern the withdrawal of life-sustaining medical treatment and supportive care. Any judicial resolution of this issue should be evaluated first for the soundness of its legal reasoning. Yet, it is increasingly important that such decisions be able to attract a consensus of support from other authorities, such as medical ethicists, to whom the medical profession looks for guidance on these

457 A.2d at 1236.

In Barber, the nursing supervisor who reported the physician’s conduct to authorities testified that she was reprimanded by one of the defendants for reinstating an air mist, which she had done with the permission of another doctor, not a defendant. The defendant told her at that time that patients are taken off respirators so that they will die. Steinbock, supra note 21, at 13. The court exonerated this course of action, acknowledging that the withdrawal of nutrition was “intentional and [done] with knowledge that the patient would die.” 195 Cal. Rptr. at 494.

Of course, no court is bound to apply any particular religious or ethical definition of euthanasia in addressing cases of this type. Likewise, however, no court is bound to follow any one expert’s interpretation of the stance of the Vatican or other religious body. If such religious documents are to be accorded the deference which has become common among judicial opinions in this area, then the entire document should be taken under consideration, not merely those portions which are cited to the court by the adversaries. Like any other document, the Vatican Declaration speaks for itself, and raises questions which were not adequately addressed by either of the experts testifying in Barber and Conroy.

195 Cal. Rptr. at 493. 196 The California Secretary of Health and Welfare charges that Medicare “countenances such improperly directed technological sophistication that more and more elderly find themselves signing ‘living wills’ to prevent expenditures of hundreds and thousands of dollars and untold family anguish as they are kept alive in conditions under which they’d rather be dead.” Swapp, Medicare Crisis Is Only a Symptom, Wall St. J., Jan. 4, 1984, at 30.

issues. Therefore, any evaluation of the Barber and Conroy opinions should look both to their legal and ethical reasoning in order to determine which court has better served the rights of patients, and preservation of high standards of medical ethics.

We have earlier discussed the merits of Conroy’s application of the balancing test between the right to privacy and the state interest in preserving life as established by Quinlan. Under Quinlan, that test must be applied in light of two factors: the gravity of the patient’s condition, and the intrusiveness of the treatment that is sought to be withdrawn. Although some may fault the conclusions reached by Conroy with respect to these balancing tests, there is no question that the test was applied, and that the court had clear factual grounds for distinguishing the cases of Ms. Conroy and Ms. Quinlan both on the question of medical condition and the question of intrusiveness.

By contrast, the Barber court, though it purported to follow Quinlan and cited dicta of that opinion, did not enter into this balancing test at all. In response to the prosecution’s attempt to draw a distinction between the withdrawal of the respirator and the withdrawal of Mr. Herbert’s intravenous feeding tube, the court stated that:

The distinction urged seems to be based more on the emotional symbolism of providing food and water to those incapable of providing for themselves rather than on any rational difference.... Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration. Their benefits and burdens ought to be evaluated in the same manner as any other medical procedure.

While the benefit/burden analysis is a legitimate ethical approach in such cases, the Barber court failed to articulate or apply the analysis with any rigor, and thus left its opinion devoid of any useful analytical tools that could be applied to other cases. Key to the court’s deficiencies in this area is its failure to confront the extraordinary haste with which the respirator and IV tube were removed from Mr. Herbert. Under these circumstances, it is difficult to discern the burden to Mr. Herbert if nutritional therapy had been continued for a period of days or weeks sufficient to confirm the original diagnosis. Certainly, there was some

166 See text accompanying notes 152-65, supra.
170 See id. at notes 120-51, supra.
171 Id.
172 195 Cal. Rptr. at 490.
173 See note 166, supra.
benefit to continuation of such therapy, since it would have allowed further investigation into whether the patient had any chance of recovery. The court apparently felt that continued existence could be of no benefit to Mr. Herbert since he had "virtually no chance of recovering his cognitive or motor functions."174 In fact, testimony established that Mr. Herbert’s neurological prognosis only slipped from "poor" to "nil" four days after the withdrawal of nourishment.175 This fact alone would seem to rebut the contention that the nourishment was of no benefit to the patient, and common sense would seem to dictate that at least a temporary continuation of nutritional therapy would constitute no significant burden in such circumstances. Mr. Herbert’s continued existence was not painful to him, nor, of course, was the IV therapy.

If the Barber court had addressed the benefit/burden issue in such a fashion, it would have had much greater difficulty in establishing that the doctors had absolutely no duty to provide Mr. Herbert with nourishment. In fact, the court’s contention that the doctors’ behavior comported with sound medical practice is directly contradicted by several of the authorities cited in the opinion, notably the Report of the President’s Commission.176 Although certain authorities state that a diagnosis of permanent unconsciousness may be made within days of the patient’s entry into coma, the Commission nevertheless concludes that, "[c]ertainly, extended observation is appropriate before making a diagnosis of permanent unconsciousness," especially in the case of hypoxic, non-traumatic injury such as Mr. Herbert’s.177

The Judicial Council of the American Medical Association confirmed the need for caution and medical certainty in its 1982 statement on the removal of life support systems: "Where a terminally ill patient’s coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support may be discontinued."178 Judged in light of this standard, the withdrawal of Mr. Herbert’s life-support systems, including the respirator and the IV tube, was surely precipitous.

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174 195 Cal. Rptr. at 492.
175 Barry, supra note 43, at 12. The President’s Commission notes that only 12% of patients with nontraumatic or hypoxic coma develop a permanent vegetative state. Over 50% die within two weeks of the hypoxic incident. REPORT OF THE PRESIDENT’S COMMISSION, supra note 7, at 179-80.
176 Id.
177 Id. at 180.
178 JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION, OPINIONS §2.11 (1982).

Hence, the Barber court overstated its case by its implication that the actions of the physicians were in full accord with the standards of ethical medical practice. As a consequence of exonerating the physicians of criminal liability, the court structured a civil law standard that is not only at odds with what has been established by Quinlan and its progeny, but also, with the consensus that has been established in the study of medical ethics.179 In addition, by giving its imprimatur to the withdrawal of treatment from a patient who had been diagnosed as unconscious prior to the time generally considered necessary to render a diagnosis of permanent coma, the Barber opinion gives insufficient consideration to the rights of patients to receive treatment. This is a problem which plagues virtually all of the jurisprudence on withdrawal of medical treatment: in focusing so much on the patient’s right to forego treatment, the courts fail to consider that incompetent patients may have (at least) an equal right to receive treatment. This delinquency is particularly acute in the case of Mr. Herbert, who had at least a small statistical chance of recovery at the time his life-support was removed. On this basis, the argument that Mr. Herbert had a right to continued intravenous feeding until such time as a certain diagnosis of his condition could be rendered would certainly be credible. It is a major flaw in the Barber opinion that Mr. Herbert’s right to receive such treatment and supportive care is nowhere considered.

The Barber court did take into account the wishes of the Herbert family, and assumed that the family’s choices would most closely correspond to those of the patient himself.180 However, such an assumption is tenuous in this case where the family may have been given faulty information on the condition of the patient prior to the withdrawal of life support systems,181 and where the continuation of his life for an interval necessary to make a precise determination of his condition could represent a far greater burden, emotional and physical, upon the family than it would upon the patient himself. Such considerations have led other courts to require evaluation of individual cases, either by a court, or by an institutional ethics committee, before certain means of life support may be withdrawn.182 Routine judicial review of such decisions would constitute an intolerable intrusion into medical practice, as well as the resources of the judiciary. Nevertheless, where there is an impasse among

179 See Horan & Grant, supra note 13.
180 105 Cal. Rptr. at 493.
181 See notes 49-50 and accompanying text, supra.
182 Compare Quinlan, 355 A.2d at 663, with Saikewicz, 370 N.E.2d at 434.
physicians, the family, and the institution on a treatment issue, the courts must be available, and in making their decisions, should have as their foremost concern the preservation of the rights of the patient, including the right to live, and the maintenance of high standards of medical ethics. These paramount interests are, unfortunately, ill-served by the opinion in *Barber*.

*Conroy*, on the other hand, exhibited the appropriate judicial concern both for patients’ rights and sound medical ethics. Although it rigidly applied the *Quinlan* right of privacy doctrine, the New Jersey court recognized the potential for abuse of patients’ rights that is inherent in the doctrine’s creation of a constitutional right that may be exercised by proxy. Fearing the uses to which this authority could be put with regards to the elderly, and residents of state institutions, the court wrote a corollary to *Quinlan* that makes certain in diagnosis of terminal condition or permanent comatose state a prerequisite to withdrawal of life-sustaining treatment. Moreover, by questioning whether nourishment may ever be legitimately withdrawn from a patient, the court forthrightly acknowledged a presumption in favor of continued treatment that serves to counterbalance the presumption, articulated in *Quinlan*, that incompetent patients would, if they were able, choose not to sustain life. However true such a statement may have been in the case of Karen Quinlan, its extension to general categories of incompetent patients with life-threatening diseases would serve as a disingenuous justification for “benign medical neglect” of such patients.

183 See Storar, 420 N.E.2d at 73.
184 464 A.2d at 310. See text accompanying notes 147-50, supra.
185 464 A.2d at 310.
186 355 A.2d at 663-64.
187 Paul Ramsey has criticized the Quinlan opinion as “open[ing] a large hole in the law” which will “erode the moral prohibition and the legal protections against involuntary euthanasia.” P. Ramsey, supra note 2, at 268, 269. In support of this thesis, Ramsey explains: The court imputed to Karen a will to die; it did not discover it. Then the court permitted others also to impute a will to die to an uncomprehending patient and to act on behalf of that patient’s privacy so construed. It does not matter who is the designated agent; others now have an extraordinary, extralegal power to bring death. And as we have seen the court did invoke the concurrence of everyone in our society in the conditions of human existence judged not to be worth preserving. It does not matter that the conditions of life needed to impute a will to die to an uncomprehending patient are now assessed by somewhat narrow criteria: impending death and irrevocability of cognitive and patient life. Indeed the court first vacillated between these two tests and then put its weight on the second. Less narrow appraisals of conditions under which no one would or should want to live will begin to be used.

Id. at 294.

The *Conroy* court also addressed itself to the ethical literature on withdrawal of treatment, particularly on nourishment, stating, “[w]hile we are satisfied that the proper balance between preservation of life and the patient’s right to privacy requires the result we have here reached, we are also persuaded that this result is dictated by ethical concerns as well.” The court used the familiar “ordinary” versus “extraordinary” means test as the framework of its analysis, emphasizing that these terms do not relate primarily to the frequency of use of a particular treatment, but to the burdensomeness and effectiveness of the treatments. The question, as the court notes, is whether feeding a patient can ever be considered “extraordinary,” and hence, optional. Recent opinions issued by such mainstream ethical authorities as the President’s Commission and the AMA Judicial Council have stated that withdrawal of nourishment from patients who will never regain consciousness may be permitted. The court declined to state whether such standards would be acceptable under law, but ruled that even under these standards, withdrawal of nourishment from Ms. Conroy would not have been permissible, since the patient was neither terminally ill, irreversibly comatose, or permanently vegetative. Under such circumstances, where the patient is not comatose or facing imminent death, “nourishment accomplishes the substantial benefit of sustaining life until the illness takes its natural course,” and thus, the court held, “nourishment always will be an essential element of ordinary care which physicians are ethically obligated to provide.”

A second ethical issue, broader than the ordinary/extraordinary means analysis applied to the case of Ms. Conroy, involves the role of judiciary and society in setting standards for the practice of medicine. Citing *Quinlan*, the court reaffirmed that determinations regarding life-prolonging treatment “must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large.” Thus, medical judgment is entitled to deference by the courts and society.
only in those cases in which, because of the condition of the patient and the nature of the life support system, the issue of sustaining life is not readily amenable to judicial resolution but is a matter for medical consensus based upon prevailing standards of practice and ethics. ... *Quinlan*, involving an irreversibly comatose patient sustained by sophisticated and complex devices, presented just such a situation. This case does not. In our view, withdrawal of a nasogastric tube from a noncomatose patient not facing imminent death is not a method of “easing and comforting the dying” which either the court or society can tolerate. 196

The court concluded with its own analysis of why the withdrawal of the feeding tube would violate medical ethics. As an extension of the Hippocratic principle, “First, do no harm,” classical medical ethics has “long distinguished between killing [euthanasia] and letting die [antidysthansasia].” 197 The resolution of disputes over medical treatment often turns upon the court’s understanding of whether the withdrawal of treatment would constitute euthanasia, which is considered unethical, and antidysthansasia, which has gained wide acceptance in the medical community, and accordingly, in medical jurisprudence. In this case, however, the trial judge upset this careful jurisprudential balance by, in the appellate court’s words, authorizing euthanasia of Ms. Conroy. 198

If the trial judge’s order had been enforced, Conroy would not have died as the result of an existing medical condition, but rather she would have died, and painfully so, as the result of a new and independent condition: dehydration and starvation. Thus, she would have been actively killed by independent means rather than allowed to die of existing illness or injury. Instead of easing her passage from life, the result of the judge’s order would have been to inflict new suffering. 199

To allow such a precedent to stand, the court said, would have “frightening implications.” Allowing a patient, guardian, or physician to determine that a non-terminal patient’s life is “worthless” involves a judgment of the patient’s quality of life, and the same judgment “could be applied with equal force to circumstances much different and less compelling than those present here.” 200

Ironically, the trial judge had acknowledged a similar concern for the potential effect of his decision, 201 but apparently felt that this was an acceptable risk and must defer to Ms. Conroy’s “right” not to have her life prolonged by artificial feeding. 202 In reversing Judge Stanton, the appellate court wisely recognized that sound ethical concern for Ms. Conroy’s rights mandated continued feeding, and that sound judicial concern for the rights of other incompetent patients warranted an affirmation that, notwithstanding *Quinlan*, euthanasia, whether by active measures or medical neglect, remains condemned in medical ethics, public policy, and the law.

CONCLUSION

The development of medical jurisprudence on the withdrawal of lifesustaining medical treatment entered a new phase with the divergent opinions rendered by appellate courts in California and New Jersey respectively in *People v. Barber* and Matter of Conroy. These opinions have both responded to, and spurred increased interest in, the debate over whether nourishment by nasogastric tube, intravenous tube, or other “mechanical” measures can ever be withdrawn from a patient. Such decisions are fraught with ethical and legal controversy: while some argue that there is logically no difference between withdrawing nourishment and withdrawing treatments such as respirators and hemodialysis, there is clearly resistance among physicians, ethicists, and legal authorities to considering nourishment on a par with other life-support systems. However, the basic fact that withdrawal of nourishment introduces a new cause of death—dehydration and starvation—that may not be related to the underlying disease, constitutes adequate empirical grounds for demanding a more cautious legal approach, if not a different rule of law, for cases involving withdrawal of nourishment.

In the effort to find an acceptable legal approach, the California opinion in *Barber* will prove of little use. The court’s absolute deference to the questionable practices of the physicians in this case ignores the responsibility of the law to safeguard patient rights and high standards of medical ethics. Moreover, the opinion quite simply fails to justify the court’s holding that withdrawal of all life-support measures from an unconscious and possibly comatose patient within five days of anoxic trauma constitutes sound, ethical medical practice. The court, in exoner-

196 464 A.2d at 314.
197 Id.
198 Id.
199 Id. at 315.
200 Id.
201 457 A.2d at 1236.
202 “Her life has become impossibly and permanently burdensome for her. Prolonging her life would not help her. It would be a wrong to her.” Id.
ating the physicians of criminal liability, went much further than necessary by holding that there was no duty whatever to treat this patient. It is to be hoped the the Conroy opinion of the New Jersey appellate panel will have a far greater impact on the developing law in this area. The court displayed a noteworthy sensitivity to the two-fold rights of incompetent patients—the right to be treated, and the right not to be overtreated—as well as to the ethical debate surrounding nourishment of seriously-ill patients. By reaffirming that the withdrawal of life-support measures from the terminally-ill and permanently comatose does not justify euthanasia of these, or other classes of patients, the court took a significant step towards preserving the sometimes shaky medico-legal consensus on treatment issues that has developed since the promulgation of Quinlan. Most importantly, Conroy ensured that the constitutional right to privacy that lies at the heart of Quinlan will not be allowed to open the door for the legalization of euthanasia. Such vigilance is essential if a medical ethics that preserves the rights of individual patients is to be enshrined in our jurisprudence.