Withholding or Withdrawing Artificial Nutrition and Hydration From Terminally Ill and Permanently Unconscious Patients: Some Recent Case Law and Contemporary Catholic Theology

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WITHHOLDING OR WITHDRAWING ARTIFICIAL NUTRITION AND HYDRATION FROM TERMINALLY ILL AND PERMANENTLY UNCONSCIOUS PATIENTS: SOME RECENT CASE LAW AND CONTEMPORARY CATHOLIC THEOLOGY

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I. Introduction

Since the landmark "right-to-die" case, In re Quinlan, society has endeavored to resolve the intricate and profound issues raised by the withholding or withdrawal of life-sustaining medical treatment. One

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2 For an extensive and authoritative study addressing the issues raised in deciding to withhold or withdraw life-sustaining medical treatment, see President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment (1983) [hereinafter President's Commis-
prominent issue, now frequently addressed, relates to the propriety of withholding or withdrawing "artificial nutrition and hydration" from terminally ill and "permanently unconscious" patients. In the absence of


See Bayer, Perspectives from Catholic Theology, in By No Extraordinary Means 89, 92 (J. Lynn ed. 1986). Father Bayer stated:

"the phrase "terminally ill" is, as many Catholic moralists warn, dangerously vague. What it should really mean is "the last phases of terminal illness." In other words, the illness must be of such a nature that, no matter what one does medically . . . the person is going to die within a rather short time."

Id.; see Unif. Rights of the Terminally Ill Act § 1(9) (Proposed Official Draft by the National Conference of Commissioners on Uniform State Laws, 1985). The proposed Act defines "terminal condition" as a condition which, without life-sustaining treatment, will "result in death within a relatively short time." Id.; see also In re Conroy, 98 N.J. 321, 342, 486 A.2d 1209, 1219 (1985) (death within approximately one year even with treatment); In re Requena, 213 N.J. Super. 475, 478, 517 A.2d 886, 888 (Ch. Div.) (patient may survive several years with treatment, but probably only a few weeks without), aff'd, 213 N.J. Super. 443, 517 A.2d 869 (App. Div. 1986); Cantor, Conroy, Best Interests, and the Handling of Dying Patients, 37 Rutgers L. Rev. 543, 547-48 (1985) (death need not be imminent—Conroy court recognized that patient's right of bodily integrity is "as applicable six months before the moment of death as six minutes before"). The definition proposed by the President's Commission is somewhat unique. The Commission, declining to use "ironclad categories" to describe particular patients, asserted that "terminally ill" was to be used as merely a "descriptive term" which would reflect a patient-based assessment and refer to patients "whose illness is likely to cause death within what is to that person a very short time."

Id.; see supra note 2, at 26.

This Article will use the term "permanently unconscious," as did the President's Commission, to refer generally to patients in either a deep coma or persistent vegetative state. See President's Commission, supra note 2, at 174 n.9. The term denotes those patients "in whom all possible components of mental life are absent—all thought, feeling, sensation, desire, emotion, and awareness of self or environment." Id. at 174. See generally id. at 170-81 (discussing type of patients who fall within term "permanently unconscious").

Society for the Right to Die, supra note 3, at 1.

The subject of withholding or withdrawing technologically supplied nutrition and hydration . . . from terminally ill and permanently unconscious patients has moved into the foreground of right-to-die issues during the '80s. According to an American
specific legislation aimed at resolving this difficult issue, courts have attempted to define the contours of the patient's prerogative in particular adjudications.\(^7\) Formulation of public policy aimed at resolving the legal, moral, and ethical dilemmas raised by life-sustaining medical treatment decisions necessitates the concerted scrutiny most aptly provided by the legislative branch in order to clarify the rights and duties of patients, their families, health care professionals, and health care institutions.\(^8\) Traditionally, the pastoral authorities of the Catholic Church and Catholic theologians have attempted to delineate the parameters of morally acceptable medical practice.\(^9\) Church teaching, however, has not definitively resolved the question of the propriety of withholding or withdrawing artificial nutrition and hydration from terminally ill and permanently unconscious patients.\(^10\) Clarification of the Church's position would alleviate the quandary presently troubling health care providers and decision-makers within the Catholic community and, simultaneously, would provide the law-making bodies ultimately responsible for defining the rights and obli-

Medical Association estimate, on any given day in the United States there are approximately 10,000 individuals... permanently unconscious conditions who are maintained by tubal feedings.

Id.\(^7\) See, e.g., Conroy, 98 N.J. at 345, 486 A.2d at 1221 (court may not avoid issue simply because it is troublesome or difficult). The Conroy court noted, however, that the legislature would be the best body for formulating "clear standards for resolving requests to terminate life-sustaining treatment." Id. at 344, 486 A.2d at 1220.

* Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980). In Perlmutter, the Florida Supreme Court commented:

Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is... an issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized.

Id.

The concerted effort required to scrutinize and weigh relevant personal and societal interests in an effort to formulate acceptable policies to guide decisions concerning life-sustaining medical treatment is exemplified by the work of the New York State Task Force on Life and the Law. After a detailed study, the Task Force, composed of doctors, ethicists, lawyers, and others, reported to the Governor that legislation was necessary to guide the issuance of do-not-resuscitate-orders ("DNR"). See New York State Task Force on Life and the Law, Do Not Resuscitate Orders 18 (1986). In its report to the Governor, the Task Force proposed legislation, see id. at 76, which the legislature largely incorporated into a statute passed in 1987. See N.Y. Pub. Health Law §§ 2960-2978 (McKinney Supp. 1988).

* See infra notes 85-121 and accompanying text.

\(^7\) See The Long Island Catholic, Jan. 21, 1988, at 1, col. 2 (quoting statement by Monsignor Orville Griese of the Pope John XXIII Medical-Moral Research and Education Center, Braintree, Mass., that issue was "an open question"); infra note 96 and accompanying text.
gations of citizens with persuasive and instructive guidance.\textsuperscript{11}

This Article will discuss the background of the legally recognized right to refuse medical treatment, and will focus on the considerations involved in determining the propriety of withholding or withdrawing artificial nutrition and hydration from terminally ill and permanently unconscious patients. Recent New Jersey cases, defining the contours of the patient's prerogative regarding artificial nutrition and hydration, and recent New York cases, which illustrate the developments in a jurisdiction currently addressing this issue, will be examined. In addition, this Article will discuss contemporary Catholic moral theology pertaining to the subject.

II. Some Recent Case Law on Withholding or Withdrawing Artificial Nutrition and Hydration

A. Right to Refuse Medical Treatment

The right of competent adults (as well as incompetent adults whose rights may be exercised through surrogate decision-makers) to refuse medical treatment has its genesis primarily in two sources: the common-law right of self-determination and bodily integrity,\textsuperscript{2} presently embodied in the doctrine of informed consent,\textsuperscript{3} and the right of privacy protected by either the state or federal Constitutions.\textsuperscript{4}

\textsuperscript{11} See infra note 128 and accompanying text.

\textsuperscript{12} See Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). Judge Cardozo, writing for the court, stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." \textit{Id.} at 129, 105 N.E. at 93.


Regardless of the source of the asserted right to refuse medical treatment, courts have generally recognized that the right is not absolute, but rather, may be limited by four potentially countervailing state interests. These interests are the preservation of life, prevention of suicide, maintenance of the integrity of the medical profession, and protection of innocent third parties. When a patient asserts his or her right to decline life-sustaining medical treatment, each of the foregoing state interests should be balanced against that right based on the particular facts and circumstances.

B. The New Jersey Supreme Court on Withholding or Withdrawing Artificial Nutrition and Hydration

Presently, an issue of particular significance is the propriety of extending a patient's right to refuse life-sustaining medical treatment such that it encompasses the right to refuse artificial nutrition and hydration. Recently, the New Jersey Supreme Court, in *In re Peter*, was faced with setting guidelines and procedures under which a life-sustaining artificial...
feeding tube—a nasogastric tube—could be removed from a sixty-five-year-old nursing home patient; this patient was in a persistent vegetative state and, although she had no hope of recovery, was capable of surviving with the life-sustaining treatment for an indeterminate time. To guide its determination, the New Jersey court looked to its prior decisions in the seminal cases of In re Quinlan and In re Conroy. A comprehensive analysis of these cases is beyond the purview of this Article, but a terse explication of their salient aspects should be profitable.

In Quinlan, the New Jersey Supreme Court allowed the guardian and family of a young adult patient, Karen Quinlan, who existed in a persistent vegetative state, to effectuate Karen’s right to refuse life-sustaining medical treatment. The court required that these surrogate decision-makers use their “best judgment” in deciding whether Karen would have exercised her right through procedures the court established for removal of the life-support apparatus—a respirator.

In Conroy, the court addressed the issue of withholding or withdrawing a nasogastric tube from an incompetent, elderly nursing home patient with “severe and permanent mental and physical impairments” and a life expectancy of less than one year. The Conroy court, rather than adopt-

18 Id. at 370, 529 A.2d at 421-22. The patient, Hilda Peter, due to her incompetency, was only able to assert her rights of self-determination and privacy through a surrogate decision-maker. Id. at 370-71, 529 A.2d at 422. New Jersey recognizes that “[a]ll patients, competent or incompetent, with some limited cognitive ability or in a persistent vegetative state, terminally ill or not terminally ill, are entitled to choose whether or not they want life-sustaining medical treatment.” Id. at 372, 529 A.2d at 423.
21 Quinlan, 70 N.J. at 41-42, 355 A.2d at 664.
22 Id. at 41, 355 A.2d at 664. In order to remove the respirator without any participant incurring civil or criminal liability, the court required the concurrence of the family, guardian, and attending physician. Id. at 54, 355 A.2d at 671. In addition, the court mandated that the attending physician must conclude that Karen would have no reasonable chance of returning to a “cognitive, sapient state,” and that after the physicians shall have consulted with a hospital “Ethics Committee” or like body, that consultative body must concur in the attending physician’s prognosis. Id.
23 Conroy, 98 N.J. at 335, 486 A.2d at 1216. Even though Ms. Conroy died with the nasogastric tube in tact, while the case was pending an appeal from the trial court, the supreme court, believing that the matter was of substantial importance and capable of repetition yet evading review, nonetheless, rendered a decision on the merits. Id. at 342, 486 A.2d at 1219. The court insisted that patients like Ms. Conroy—formerly competent, institutionalized, and elderly with less than one year to live—do not lose their right to determine the course of their medical treatment because of subsequent incompetency, and considered it the goal of a surrogate decision-maker to determine and effectuate, as far as possible, the decision the patient would make if he or she was competent. See id. at 359-60, 486 A.2d at 1229.
ing the guidelines and procedures established in *Quinlan*, limited *Quinlan* to the category of patients which it addressed—those in a persistent vegetative state or comatose. The court, instead, pronounced three tests, any one of which must be satisfied before a surrogate's decision to withhold or withdraw life-sustaining treatment from an incompetent, nursing home patient could be lawfully exercised.

The first test, the "subjective test," is satisfied where it is "clear that the particular patient would have refused the treatment under the circumstances involved." Under *Conroy*'s "subjective test," a surrogate decision-maker must be sufficiently informed to reach a decision, in the same manner that a competent patient must be informed to render an informed consent or refusal. Perhaps the best evidence of the patient's subjective intent prior to becoming incompetent depends upon the facts and circumstances under which the patient expressed his treatment preferences, with consideration given to such factors as the patient's maturity and the "remoteness, consistency and thoughtfulness of the prior statements or actions." *Conroy*, 98 N.J. at 362, 486 A.2d at 1230. See generally N. Cantor, *Legal Frontiers of Death and Dying* 67 (1987) (substituted judgment allows implementation of patient's aberrational wishes) and *Society for the Right to Die*, *The Physician and the Hopelessly Ill Patient* 27 (1985) (implementation of patient's choice not necessarily in patient's best interest, even if objectively irrational) with *President's Commission*, supra note 2, at 133 (at some level, decisions potentially adverse to patient's interests can only be chosen directly by competent patient). The probative value of the evidence of the patient's subjective intent prior to becoming incompetent depends upon the facts and circumstances under which the patient expressed his treatment preferences, with consideration given to such factors as the patient's maturity and the "remoteness, consistency and thoughtfulness of the prior statements or actions." *Conroy*, 98 N.J. at 362, 486 A.2d at 1230. See generally N. Cantor, * supra*, at 63-67 (discussing principles of substituted judgment, limits to its utility, and problems encountered in its application). For a related view, compare Eichner v. Dillon, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981), where the New York Court of Appeals required "clear and convincing" proof of the previously expressed desires of a formerly competent, eighty-three year old patient not to be maintained in a vegetative state on a respirator. See id. at 378-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. This view requires that the patient's specific desires be known and articulated to the health care provider, and may be distinguished from the view that the family or representative choose on behalf of the patient based upon inferences of his treatment preferences under the facts and circumstances. See *Society for the Right to Die*, supra, at 27. Other New York cases requiring proof of the previously expressed desires of a formerly competent patient include the following: Delio v. Westchester County Medical Center, 129 App. Div. 2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987); In re Strauss, N.Y.L.J., July 30, 1987, at 12, col. 3 (Sup. Ct. Bronx County); In re O'Brien (Kerr), 135 Misc. 2d 1076, 517 N.Y.S.2d 346 (Sup. Ct. N.Y. County 1986); In re Lydia E. Hall Hosp. Cinque), 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. Nassau County 1982).

See *Conroy*, 98 N.J. at 363, 486 A.2d at 1231. Relevant information would include the patient's "level of physical, sensory, emotional, and cognitive functioning; . . . degree of

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* Id. at 358-59, 374-75, 486 A.2d at 1228, 1237.
* See id. at 360-68, 486 A.2d at 1229-33.
* Id. at 360, 486 A.2d at 1229. This type of approach, commonly referred to as "substituted judgment," attempts to effectuate the choice the incapacitated person would make if capable to choose. See id. at 360-61, 486 A.2d at 1229; *President's Commission*, supra note 2, at 132. One problem likely to be encountered by a surrogate decision-maker arises when such decision-maker attempts to make a decision perceptibly adverse to the patient's best interests, but arguably the choice the patient would have made if capable. Compare N. Cantor, *Legal Frontiers of Death and Dying* 67 (1987) (substituted judgment allows implementation of patient's aberrational wishes) and *Society for the Right to Die*, *The Physician and the Hopelessly Ill Patient* 27 (1985) (implementation of patient's choice not necessarily in patient's best interest, even if objectively irrational) with *President's Commission*, supra note 2, at 133 (at some level, decisions potentially adverse to patient's interests can only be chosen directly by competent patient). The probative value of the evidence of the patient's subjective intent prior to becoming incompetent depends upon the facts and circumstances under which the patient expressed his treatment preferences, with consideration given to such factors as the patient's maturity and the "remoteness, consistency and thoughtfulness of the prior statements or actions." *Conroy*, 98 N.J. at 362, 486 A.2d at 1230. See generally N. Cantor, * supra*, at 63-67 (discussing principles of substituted judgment, limits to its utility, and problems encountered in its application). For a related view, compare Eichner v. Dillon, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981), where the New York Court of Appeals required "clear and convincing" proof of the previously expressed desires of a formerly competent, eighty-three year old patient not to be maintained in a vegetative state on a respirator. See id. at 378-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. This view requires that the patient's specific desires be known and articulated to the health care provider, and may be distinguished from the view that the family or representative choose on behalf of the patient based upon inferences of his treatment preferences under the facts and circumstances. See *Society for the Right to Die*, supra, at 27. Other New York cases requiring proof of the previously expressed desires of a formerly competent patient include the following: Delio v. Westchester County Medical Center, 129 App. Div. 2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987); In re Strauss, N.Y.L.J., July 30, 1987, at 12, col. 3 (Sup. Ct. Bronx County); In re O'Brien (Kerr), 135 Misc. 2d 1076, 517 N.Y.S.2d 346 (Sup. Ct. N.Y. County 1986); In re Lydia E. Hall Hosp. (Cinque), 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. Nassau County 1982).
subjective intent to forego certain types of life-sustaining medical procedures is a signed, dated, and witnessed written document, known as a "living will," under which a patient's prior directive authorizes the withholding or withdrawal of life-sustaining medical procedures in specified circumstances.** Other evidence may include oral directives to family or

** See In re Peter, 108 N.J. 370, 529 A.2d 419 (1987). For a list of the thirty-nine jurisdictions—thirty-eight states and the District of Columbia—that have enacted laws referred to as “living will” or “natural death” legislation, see In re Farrell, 108 N.J. 335, 342 n.2, 529 A.2d 404, 407 n.2 (1987). See also P. Williams, Living Will Source Book with Forms (1986) (containing state natural death laws governing execution of living wills, state mandated living will forms, and generic form with instructions for effectuating execution of living will in states without such legislation). Additionally, the National Conference of Commissioners on Uniform State Laws has approved and recommended model legislation governing advanced directives by an adult in a “terminal condition” and incapable of participating in decisions regarding life-sustaining medical treatment. See Unif. Rights of the Terminally Ill Act (Proposed Official Draft by the National Conference of Commissioners on Uniform State Laws, 1985). The proposed Act is not without criticism. See Statement of the National Conference of Catholic Bishops, Committee for Pro-life Activities, in The Rights of the Terminally Ill, 16 Origins 222 (1986) [hereinafter U.S. Bishops’ Committee for Pro-Life Activities]; Marzen, "The Uniform Rights of the Terminally Ill Act": A Critical Analysis, 1 Issues in L. & Med. 441 (1986). The “Society for the Right to Die,” a key participant in shaping the substantive contours of right-to-die issues, serves as a source of informative literature in this area, and offers individuals information, counseling, and assistance in implementing or understanding living wills. They are located at 250 West 57th Street, New York, N.Y. 10107.

New York does not presently have a statute governing living wills. See generally New York State Task Force on Life and the Law, Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent 76, 85 n.8 (1987) [hereinafter Task Force] (New York has no such legislation though five bills were introduced during 1986-1987 legislative session); Note, To Die or Not to Die: The New York Legislature Ponders a Natural Death Act, 13 Fordham Urb. L.J. 639 (1985) (recommending that the New York legislature adopt a living will statute). However, in the context of a declaratory judgment action, a New York court deemed the petitioner’s proposed living will to be something of an “informed medical consent statement” and “evidence of the most persuasive quality and . . . a clear and convincing demonstration” of her desires while competent. See Saunders v. State, 129 Misc. 2d 45, 54, 492 N.Y.S.2d 510, 517 (Sup. Ct. Nassau County 1985). A living will may, nevertheless, leave doubt as to a previously competent patient’s desires when the decision regarding life-sustaining treatment finally arises. See, e.g., Evans v. Bellevue Hosp., N.Y.L.J., July 28, 1987, at 11, col. 1 (Sup. Ct. N.Y. County) (court will not resort to “speculation and conjecture” to resolve meaning of “amorphous expression” in patient’s living will). See generally Task Force, supra, at 75-77 (1987) (discussing uncertainty of usefulness of living wills in New York and results of survey of hospitals and nursing homes).


humiliation, dependence and loss of dignity . . . resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits.” Id. at 363-64, 486 A.2d at 1231.

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physician, or a durable power of attorney or other vehicle authorizing an agent to make decisions in the patient’s behalf. Additionally, evidence of intent may be deduced from a patient’s religious beliefs and the tenets of that religion.

The other two tests formulated by the court, the “limited-objective” and “pure-objective” tests, were designed for situations where there is insufficient evidence of the patient’s wishes to forego life-sus-

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**Conroy,** 98 N.J. at 361, 486 A.2d at 1229-30. In Peter, the court construed the state’s durable power of attorney statute to authorize conveyance of durable authority to make medical decisions. Peter, 108 N.J. at 378, 529 A.2d at 426; see also Note, Appointing an Agent to Make Medical Treatment Choices, 84 Colum. L. Rev. 985, 1015-20 (1984) (recommending such construction of durable power of attorney statutes). See generally Moore, The Durable Power of Attorney as an Alternative to the Improper Use of Conservatorship for Health-Care Decision-Making, 60 St. John’s L. Rev. 631 (1986) (analysis of methods utilized in surrogate decision-making suggesting that durable power of attorney be adopted as ideal method for surrogate health care decision-making). The combined execution of a living will and a durable power of attorney delegating authority to make health care decisions could enhance the effectuation of an individual’s wishes regarding medical treatment. See id. at 673. See generally President’s Commission, supra note 2, at 145-47 (encouraging use of durable power of attorney statutes in making decisions for incompetent patients).

However, because of uncertainty over whether durable power of attorney statutes permit delegation of authority respecting health care decisions, a number of states have legislatively sanctioned the appointment of agents to make health care decisions through specific legislation, amendment of durable power of attorney statutes, or direct incorporation in living will legislation. See Task Force, supra note 28, at 79 (referring to and citing sixteen state statutes). In its study, the New York State Task Force on Life and the Law ultimately proposed “health care proxy” legislation specifically providing for the appointment of an agent to make health care decisions for those who subsequently lose decision-making capacity. See id. at 71-139, 149-59.

**Conroy,** 98 N.J. at 361-62, 486 A.2d at 1230; see Eichner, 52 N.Y.2d at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. In Eichner, evidence that the patient, a Catholic Brother who existed in a persistent vegetative state, had previously expressed approval of the Pope’s pronouncement of the Catholic Church’s position—permitting the withholding or withdrawal of “extraordinary” life-sustaining treatment where the patient stood no reasonable hope of returning to cognitive life—helped establish the requisite “clear and convincing” proof of his previously expressed desires regarding removal of his respirator. See id.; see also In re Jobes, 108 N.J. 394, 412, 529 A.2d 434, 443 (1987) (tenets of patient’s religion neither required nor forbade treatment at issue; thus, patient’s religious affiliation offered little guidance as to her preferences).

**Conroy,** 98 N.J. at 365, 486 A.2d at 1232. The “limited-objective test” is satisfied where there is “some trustworthy evidence” of the patient’s wishes to forego the treatment and the surrogate decision-maker “is satisfied that it is clear that the burdens [i.e., pain and suffering] of the patient’s continued life with the treatment [markedly] outweigh the benefits [i.e., physical pleasure, emotional enjoyment, or intellectual satisfaction] of that life for him.” Id. at 686, 438 A.2d at 1232. The “pure-objective test” applies where there is no “trustworthy evidence” of the patient’s intent, and will be satisfied only where “the net burdens of the patient’s life with the treatment ... clearly and markedly outweigh the benefits that the patient derives from life” and “recurring, unavoidable and severe pain ... with the treatment” make it inhumane to administer the life-sustaining treatment. Id.
taining treatment. If either of these two tests is satisfied, the withholding or withdrawal of medical treatment is permitted under the premise that withholding or withdrawing treatment is in the patient’s "best interests."\textsuperscript{33}

\textsuperscript{33} See id. at 364-65, 486 A.2d at 1231-32. The opinion makes clear that the two “best interests” tests are restricted evaluations of the patient’s life in terms of “pain, suffering and possible enjoyment,” and are not based on the “social utility” or the quality of that life to others, thereby adding a measure of protection to the “socially isolated and defenseless people suffering from physical and mental handicaps.” Id. at 367, 486 A.2d at 1232-33. Compare the Conroy “best interests” tests to the assessment of the patient’s best interests proposed by the President’s Commission. See President’s Commission, supra note 2, at 135. The President’s Commission determined that an assessment of a patient’s best interests requires consideration of “objective, societally shared criteria,” such as “relief of suffering, preservation or restoration of functioning, and the quality as well as the extent of life sustained.” Id. For an insightful analysis and criticism of the Conroy “best interests” tests, see generally N. Cantor, supra note 26, at 68-76, and N. Cantor, supra note 4, at 563-70 (1985).

A recent New York case, In re Beth Israel Medical Center (Weinstein), N.Y.L.J., Sept. 15, 1987, at 6, col. 3 (Sup. Ct. N.Y. County), adopted the Conroy “best interests” tests in refusing medical treatment—a surgical amputation of a gangrenous leg—on behalf of an elderly, incompetent nursing home patient with a limited life expectancy, suffering from “severe and permanent mental and physical debilitating,” who had not previously made her wishes sufficiently known. Id. The court, in adopting a “best interests” analysis, gleaned legislative approval of surrogate decision-making for incompetent patients who have not provided sufficient indication of their treatment choice from section 80 of New York’s Mental Hygiene Law, which provides for surrogate decision-making at mental hygiene facilities under a “best interests” approach. See id. at 6, col. 6. The court stated that a presumption favoring life or life-prolonging procedures would prevail unless it could be “established by clear and convincing evidence that the burdens of continued life for this patient markedly outweigh the benefits that furthering life would bring.” Id. To clarify the application of the standard which the court promulgated, a dozen factors, illustrative of the considerations to be taken into account in order to weigh the benefits and the burdens, were enumerated. Id. at 7, col. 1. Ultimately, the court decided that the proposed amputation was not in the patient’s best interests. Id.

Beth Israel represents a significant step in New York case law. In the seminal case, In re Eichner, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981), the New York Court of Appeals allowed the removal of a respirator from a permanently unconscious patient based on evidence of the patient’s previously expressed competent wishes, but offered no mechanism for decision-making absent such clearly expressed desires. Furthermore, in the companion case to Eichner, the court of appeals declined to allow a “best interests” approach when it refused to allow the parent of a profoundly retarded, never competent patient to order the discontinuance of blood transfusions. Id. at 380-81, 420 N.E.2d at 73, 438 N.Y.S.2d at 275. Additionally, the court of appeals explicitly called for judicial restraint aimed at resolving issues on a case by case basis. Id. at 370 & n.2, 420 N.E.2d at 67 & n.2, 438 N.Y.S.2d at 269 & n.2. Arguably, however, Storar and Eichner preclude the adoption of surrogate decision-making under a “best interests” analysis for terminally ill or permanently unconscious patients who fail to leave sufficient evidence of their treatment.
The Peter court appropriately held that the Conroy "best interests" tests, focusing primarily on pain, are not applicable to patients in a persistent vegetative state who, "[b]y definition . . . do not experience any of the benefits or burdens that the Conroy balancing tests are intended or able to appraise." Instead, the court determined that the Conroy "subjective test" should apply "in every surrogate-refusal-of-treatment case regardless of the patient's medical condition or life expectancy," and that, under Quinlan, the proper focus regarding vegetative patients should be on the prognosis and possibility of return to cognitive, sapient life. Whereas the Conroy court found the limited life-expectancy of a severely physically impaired and demented patient to be a significant criterion, the Peter court stated that "[u]nder Quinlan, the life-expectancy of a patient in a persistent vegetative state is not an important criterion in determining whether life-sustaining treatment may be [withheld or] withdrawn." The court, applying the Conroy "subjective test," found that Ms. Peter did in fact leave clear and convincing evidence of her desire to forego treatment under the circumstances. Because the "subjective test" was held to have been satisfied, the court deemed it unnecessary to detail the application of the Quinlan guidelines to a vegetative nursing home patient. As in Conroy, the court in Peter found no dis-

preferences. See People v. Eulo, 63 N.Y.2d 341, 357, 472 N.E.2d 286, 296, 482 N.Y.S.2d 436, 446 (1984) (dictum) ("Under existing law, third parties are without authority to determine on behalf of the terminally ill that they should be permitted to die. This court will make no judgment as to what is for another an unacceptable quality of life.").

See Peter, 108 N.J. at 376-77, 529 A.2d at 425. The court believed that the benefits-burdens analysis of the Conroy "best interests" test, though difficult to apply with respect to cognitively impaired patients like Ms. Conroy, would be virtually impossible to apply to permanently unconscious patients like Ms. Peter. Id. at 376, 529 A.2d at 425.

See supra note 26 and accompanying text.

See Peter, 108 N.J. at 377, 529 A.2d at 425. Looking to the now incompetent patient's wishes in all circumstances has the salutary effect of assuring citizens that their desires regarding the dying process will not go unrecognized after they become helpless. See Cantor, supra note 4, at 556.

See Peter, 108 N.J. at 374, 529 A.2d at 424.

Id.

See id. at 377, 529 A.2d at 425.

See id. The same day it decided the Peter case, the New Jersey Supreme Court decided In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987). Jobes involved a non-elderly nursing home patient in a persistent vegetative state who did not leave sufficiently clear and convincing evidence of her desire to forego artificial nourishment under the circumstances. Id. at 399, 529 A.2d at 436. In Jobes, because the "subjective test" was not satisfied, the court was required to establish guidelines and procedures for surrogate decision-making on behalf of a non-elderly patient in a persistent vegetative state under the Quinlan approach. See id. at 412-13, 529 A.2d at 443. Adopting the Quinlan approach, which allows the family and guardian to render their "best judgment" as to what the patient would do under the circumstances, Quinlan, 70 N.J. at 41, 355 A.2d at 664, the court determined that the family and guardian need not present clear and convincing proof of the patient's intent but, instead,
tinction between withholding or withdrawing artificial feeding devices, such as a nasogastric tube, and other forms of life-sustaining treatment, such as a respirator. Furthermore, the court believed that dehydration would not necessarily be distressing or painful for a patient unable to sense thirst or hunger so that withholding or withdrawing artificial feeding would not result in more pain than termination of other medical procedures.

may infer from their presumably intimate knowledge of the patient his or her likely treatment preferences under the facts and circumstances. See Jobs, 108 N.J. at 414-15, 529 A.2d at 444-45. This is apparently a true "substituted judgment" approach.

In Conroy, the court acknowledged the perceived "emotional symbolism" of food and the psychosocial satisfaction derived by patients and care-givers from the provision of nutrition. See Conroy, 98 N.J. at 372-73, 486 A.2d at 1236; see also Callahan, On Feeding the Dying, 13 Hastings Ctr. Rep. 22, 22 (1983) (feeding hungry human beings "is the perfect symbol of the fact that human life is inescapably social and communal"); Carson, The Symbolic Significance of Giving to Eat and Drink, in By No Extraordinary Means 84, 87 (J. Lynn ed. 1986) ("symbolic significance resides in the mutuality of giving to eat and drink and of taking food and water"); Derr, Nutrition and Hydration as Elective Therapy: Brophy and Jobs from an Ethical and Historical Perspective, 2 Issues in L. & Med. 25, 33-34 (1986) (providing food and fluids has "special cultural and symbolic significance"). However, the Conroy court was persuaded that artificial feeding methods were sufficiently different from connatural methods of providing nourishment because, like many other medical procedures, they pose inherent risks and possible deleterious side effects. See Conroy, 98 N.J. at 373, 486 A.2d at 1236. For commentary discussing the various benefits and burdens posed by different artificial feeding methods, see Lo & Dornbrand, Guiding the Hand that Feeds: Caring for the Demented Elderly, 311 New Eng. J. Med. 402, 403 (1984); Lynn & Childress, supra, at 18; Major, supra note 3, at 24-27.

where the burdens of feeding outweigh the benefits, "[i]nstead of being humane care, tube feedings may be painful, invasive, and impersonal for some patients." Lo & Dornbrand, supra note 41, at 403. Doctor Lynn and Professor Childress argue that some patients may die more comfortably without artificial hydration because "[t]erminal pulmonary edema, nausea, and mental confusion are more likely when patients have been treated to maintain fluid and nutrition until close to the time of death." Lynn & Childress, supra note 41, at 19. They further note that severely demented patients requiring restraints and sedatives for effective administration of artificial nutrition could be deprived of whatever pleasant experiences that could otherwise have been available. Id.; see also Dresser & Boisaubin, supra
In addition to articulating the tests to be applied by surrogate decision-makers in reaching decisions to withhold or withdraw medical treatment, the New Jersey Supreme Court has been concerned with formulating the procedures which decision-makers would have to comply with in order to justify such decisions. In Conroy, because the court perceived differences between nursing home and hospital patients and institutions, it set forth decision-making procedures uniquely suited for incompetent, elderly nursing home patients.\textsuperscript{43} Similarly, in Peter, the court formulated procedures to safeguard the decision-making process regarding elderly nursing home patients in a persistent vegetative state.\textsuperscript{44}

\textsuperscript{43} See Conroy, 98 N.J. at 374-85, 486 A.2d at 1237-42. The court pointed to the general vulnerability and usual lack of surviving family members of nursing home residents, as well as the limited role of physicians and the unlikely presence of an "ethics" or "prognosis" committee to review an attending physician's prognosis at nursing homes as compared to hospitals. \textit{Id.} at 374-77, 486 A.2d at 1237-38. An oversight function was entrusted to the Office of the Ombudsman for the Institutionalized Elderly, a state administrative agency whose authority is legislatively mandated. \textit{Id.} at 379-80, 486 A.2d at 1239-40. Upon notification by the family, guardian, attending physician, friend, or by any person who believes there exists a possibility of "abuse" by the decision-maker, the Ombudsman must investigate the situation and within twenty-four hours report to an appropriate state agency, and should, within his discretionary power, appoint two physicians, unaffiliated with the nursing home, to secure confirmation of the patient's medical condition and prognosis. \textit{Id.} at 383-84, 486 A.2d at 1241-42. It is important to realize that the New Jersey courts have avoided becoming enmeshed in the decision-making process, preferring instead to set the guidelines and procedures in order to facilitate decision-making by interested private parties. Entrusting the oversight to the auspices of an administrative agency, peculiarly mandated to guard the interests of a particularly vulnerable class of citizens, should prove a propitious endeavor provided the agency is adequately funded and staffed and appropriately engaged by concerned parties. See, e.g., Paris & Varga, \textit{Care of the Hopelessly Ill}, 151 Am. 141, 144 (1984) (calling for system of disinterested review of decisions on behalf of institutionalized elderly).

\textsuperscript{44} See Peter, 108 N.J. at 383-84, 529 A.2d at 429. Before withholding or withdrawing life-sustaining treatment from such a patient, the surrogate decision-maker should inform the Office of the Ombudsman for the Institutionalized Elderly of that decision. \textit{Id.} After being notified, the Ombudsman should procure the opinions of two independent physicians to confirm the prognosis that there is no possibility of return to cognitive, sapient life, the outcome of discontinuing the treatment, and available medical alternatives. \textit{Id.} Only after receiving the requisite confirmations from two independent physicians should the Ombudsman defer to the decision of a properly designated surrogate decision-maker. See \textit{id.} In Peter, following adjudication of Ms. Peter's incompetency and appointment of a guardian, the guardian notified the Ombudsman and requested approval of the decision to remove the nasogastric tube. \textit{Id.} at 372, 529 A.2d at 422. Ultimately, the Ombudsman refused to consent to the removal of the nasogastric tube, and Ms. Peter's guardian appealed that determination. See \textit{id.} at 372 & n.2, 529 A.2d at 422 & n.2. Because the court found that the
C. New York Courts Address the Issue

Courts in states other than New Jersey have similarly rejected the distinction between artificial nourishment and other life-sustaining treatment in upholding a patient's right to refuse artificial nutrition and hydration. In New York, the Appellate Division, Second Department, recently addressed this issue in *Delio v. Westchester County Medical Center*. In *Delio*, the conservator of a thirty-three-year-old patient, Daniel Delio, a former exercise physiologist who was in a persistent vegetative state with no hope of recovery, had sought the removal of two surgically inserted feeding tubes. The court phrased the broad issue as "whether the common-law right to decline medical treatment ... encompasses a right to remove or withhold artificial means of nourishment and hydration." The court determined that the case fell under the rubric of *Conroy* subjective test was satisfied, the case was remanded to the Ombudsman to reconsider the guardian's request for approval of the decision to order removal of the nasogastric tube. *Id.* at 385, 529 A.2d at 430. Eventually, Ms. Peter's wishes were effectuated: the nasogastric tube was removed after approval by the Ombudsman, and Ms. Peter died at the nursing home shortly thereafter. N.Y. Times, Dec. 1, 1987, at B2, col. 5.

The Supreme Judicial Court of Massachusetts upheld the right of a patient in a persistent vegetative state to have a gastrostomy tube removed, agreeing with the *Conroy* court's view that "the primary focus should be the patient's desires and experience of pain and enjoyment—not the type of treatment involved." *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 435, 497 N.E.2d 626, 636 (1986) (quoting *Conroy*, 98 N.J. at 369, 486 A.2d at 1209). Similarly, the distinction has been rejected by other state high courts recently addressing this issue. See *Rasmussen v. Fleming*, 154 Ariz. 207, 217, 741 P.2d 674, 684 (1987); *In re Gardner*, 534 A.2d 947, 954 (Me. 1987); *In re Grant*, 109 Wash. 2d 545, 563, 747 P.2d 445, 454 (1987) (en banc).

In California, an appellate court held that a competent patient who was severely physically debilitated, but not terminally ill, had the right to have removed a nasogastric tube, which had been inserted without her consent. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1134, 225 Cal. Rptr. 297, 298 (1986). Prior to *Bouvia*, the same court, in the context of a criminal prosecution of two doctors, had found the administration of artificial nourishment indistinguishable from the use of a respirator or other forms of life-sustaining treatment. See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1016, 195 Cal. Rptr. 484, 490 (1983). A Florida appellate court found no basis for distinguishing between "forced sustenance" and "forced" continuance of vital functions, and upheld the right of an elderly patient in a persistent vegetative state to have her nasogastric tube removed. *Corbett v. D'Alessandro*, 487 So. 2d 368, 371 (Fla. Dist. Ct. App. 1986). For a list of selected state court cases involving artificial feeding, see *Society for the Right to Die*, supra note 3, at 7.

129 App. Div. 2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987).

*Id.* at 3-4, 516 N.Y.S.2d at 679-80. Medical testimony indicated that Daniel, while not technically "dead" under New York standards, see *People v. Eulo*, 63 N.Y.2d 341, 472 N.E.2d 286, 482 N.Y.S.2d 436 (1984) (irreversible cessation of all functions of the entire brain constitutes death), had no reasonable prospect for regaining cognitive awareness or consciousness, although he could be sustained indefinitely in a vegetative state. *See Delio*, 129 App. Div. 2d at 10 & n.2, 516 N.Y.S.2d at 683-84 & 684 n.2. Although Daniel had not executed a living will, the court was satisfied that the evidence adduced at the hearing below conclusively established that Daniel would have refused the artificial feeding under the circumstances. *Id.* at 6, 516 N.Y.S.2d at 681.
hydration to an individual in a persistent vegetative state with no hope of recovery.\textsuperscript{48} For guidance, the court looked to New York's seminal case, \textit{Eichner v. Dillon}.\textsuperscript{49}

\textit{Eichner} involved an eighty-three-year-old Catholic Brother, Brother Fox, who had been maintained in a persistent vegetative state with the help of a respirator due to his inability to breathe spontaneously.\textsuperscript{50} The New York Court of Appeals held that the common-law right to refuse medical treatment extends to termination of life-sustaining procedures where there is "clear and convincing" proof that the patient, while competent, personally expressed a desire to have such treatment withheld or withdrawn under the circumstances and no countervailing state interest exists which would preclude terminating the treatment.\textsuperscript{51}

As to the question of the propriety of terminating artificial nourishment, the \textit{Delio} court did not interpret \textit{Eichner} as being limited to removal of respirators. Instead, the \textit{Delio} court discerned from \textit{Eichner} that the court of appeals had focused primarily on the patient's desire to forego medical treatment, and not on the specific type of treatment involved.\textsuperscript{52} The leading New Jersey case, \textit{Conroy}, which had rejected the

\textsuperscript{48} \textit{Delio}, 129 App. Div. 2d at 2, 516 N.Y.S.2d at 679.
\textsuperscript{50} \textit{Id.} at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 269. Father Eichner, a superior of Brother Fox, sought appointment as committee of the person and property of Brother Fox and authority to order the disconnection of the respirator. \textit{Id.} at 371, 420 N.E.2d at 67, 438 N.Y.S.2d at 269. The uncontroverted testimony adduced below established that Brother Fox had no reasonable hope of recovery, and that, when competent, Brother Fox had consistently expressed the view that under such circumstances he would want the respirator removed. \textit{See id.} at 371-72, 379-80, 420 N.E.2d at 68, 72, 438 N.Y.S.2d at 270, 274.
\textsuperscript{51} \textit{See id.} at 377-80, 420 N.E.2d at 71-72, 438 N.Y.S.2d at 273-74.
\textsuperscript{52} \textit{Delio}, 129 App. Div. 2d at 16, 516 N.Y.S.2d at 687-88. The trial judge in \textit{Delio} was reluctant to extend \textit{Eichner}, which he believed was distinguishable because, whereas Brother Fox was eighty-three years old, terminally ill, and sustained by a respirator, Daniel was only thirty-three, not terminally ill, and sustained by artificial feeding. \textit{See id.} at 12, 516 N.Y.S.2d at 685. The appellate court, however, found that the age of a persistently vegetative patient is relevant only to the question of the weight of the evidence of the patient's previously expressed desires to refuse treatment. \textit{See id.} at 21, 516 N.Y.S.2d at 690. Regarding a patient's medical condition, the court stated that "while the terminal nature of an illness may be relevant in treatment decisions made by a competent person, it is of little practical relevance in cases involving a person existing in a chronic vegetative state with no hope of recovery." \textit{Id.} at 22, 516 N.Y.S.2d at 691; \textit{see also In re Peter}, 108 N.J. 365, 374-77, 529 A.2d 419, 424-25 (1987) (neither patient's life-expectancy nor nature of patient's medical condition in terms of ability to experience benefits and burdens are relevant to deciding whether to withhold or withdraw treatment from persistently vegetative patient). The court commented further that, "[i]n fact, the absence of a terminal illness may serve to reinforce the decision to discontinue life-sustaining treatment" because sustaining the patient in a vegetative condition may yield no benefits to the patient, other than "mere existence," and cause "continued indignities and dehumanization." \textit{Delio}, 129 App. Div. 2d at 22, 516 N.Y.S.2d at 691.
distinction between artificial feeding and other forms of life-sustaining procedures, was deemed persuasive and instructive. Applying the principles formulated in *Eichner*, the *Delio* court found that none of the commonly designated, potentially countervailing state interests were weighty enough to override Daniel's right to refuse medical treatment, and was satisfied that there was "clear and convincing" evidence of Daniel's desires, when competent, to have the feeding tube removed under the circumstances. Ultimately, the court upheld Daniel's right to refuse artificial nourishment.

Prior to *Delio*, a New York trial court, in *Vogel v. Forman*, declined to allow the withholding or withdrawal of artificial nourishment by refusing to authorize the removal of a nasogastric tube sustaining a permanently unconscious patient, despite testimony that the patient, when competent, had expressed a desire not to be maintained by artificial means. The same court, following the holdings of *Vogel* and the trial court's decision in *Delio*, had also recently denied a petitioner's application for the appointment of a guardian with authority to order the withdrawal of a life-sustaining nasogastric tube from a permanently unconscious patient; however, in light of the appellate decision in *Delio*, the court granted a motion to reargue and decided the petition under the binding authority of *Delio*. Under *Delio*, a patient in a persistent vegetative state with no hope of recovery, though neither terminally ill nor legally brain-dead, and arguably one with severe and permanent mental

53 *Delio*, 129 App. Div. 2d at 17, 516 N.Y.S.2d at 688. The *Conroy* court also rejected the commonly recognized distinction between "ordinary" treatment—required procedures which cannot be refused—and "extraordinary" treatment—optional procedures which may be refused. See *Conroy*, 98 N.J. at 370-71, 486 A.2d at 1234-35. The court believed that such a distinction was merely an exercise in semantics, tending to blur the substantive analysis, which should not be employed when determining whether to withhold or withdraw life-sustaining treatment. See id. For other views on the ordinary/extraordinary distinction, see infra notes 88-90 and accompanying text.

54 *Delio*, 129 App. Div. 2d at 22-26, 516 N.Y.S.2d at 691-94.

55 See *id.* at 26, 516 N.Y.S.2d at 693-94. The judgment below was reversed and the conservator authorized to direct the withdrawal of the feeding tubes. See *id.* at 26, 516 N.Y.S.2d at 694.


57 *Id.* at 397-99, 512 N.Y.S.2d at 623-24. The court drew a distinction between authorizing withdrawal of "extraordinary" life-support apparatuses from brain-dead or terminally ill patients with no hope of recovery and withdrawal of "ordinary" life-sustaining nourishment from patients who, like Mr. Vogel, are unable to care for themselves due to illness, age, or other physical incapacity. See *id.* at 398-99, 512 N.Y.S.2d at 624. The court believed that to allow withdrawal of artificial nourishment would be to sanction death by starvation and contravene the policies of the state and a humane society. *Id.*

and physical impairments with a limited life expectancy, could have artificial nourishment withheld or withdrawn. The primary focus of a court should be on the patient's desire and right to have treatment terminated under the circumstances.

In another recent case decided prior to Delio, Women's Circle Home and Infirmary for the Aged v. Fink, a New York trial court authorized the surrogate decision-makers of a terminally ill, elderly nursing home patient in a persistent vegetative state to withhold consent to the performance of a gastrostomy necessary to sustain the patient. Authorization to order the withholding or withdrawal of intravenous feeding, however, was denied, even though the court found "clear and convincing" evidence that the patient, when competent, had expressed her desire to

** See In re Beth Israel Medical Center (Weinstein), N.Y.L.J., Sept. 15, 1987, at 6, col. 3 (Sup. Ct. N.Y. County); see also In re Westchester County Medical Center, 139 App. Div. 2d 344, 532 N.Y.S.2d 133 (2d Dep't 1988). In Westchester County Medical Center, the Appellate Division, Second Department, recently upheld the right of an incompetent patient to have artificial feeding withheld or withdrawn where the patient was neither comatose nor in a persistent vegetative state, but had suffered "'irreparable'" damage due to multiple strokes, had "'no chance for a meaningful mental status recovery,'" and would "'never improve from' her present condition." Id. at 346, 532 N.Y.S.2d at 134. The majority opinion also referred to the speculation of Ms. O'Connor's attending physician that insertion of a nasogastric tube to replace intravenous feeding, which was becoming ineffective, would prolong Ms. O'Connor's life for several months to a year or two. Id. Dissenting, Justice Balletta maintained, however, that the facts proved that Ms. O'Connor's condition had not been diagnosed as terminal and that to some extent she was awake, alert, and cognizant. Id. at 353-54, 532 N.Y.S.2d at 139 (Balletta, J., dissenting). Justice Balletta believed that Ms. O'Connor's condition was not as severe as comatose, vegetative, and brain dead patients. Id. at 358, 532 N.Y.S.2d at 142 (Balletta, J., dissenting). Justice Balletta determined that New York courts have not authorized the withholding or withdrawal of artificial life-sustaining treatment where the patient is not comatose, in a persistently vegetative state, or terminally ill, and, consequently, would have refused authorization. Id. at 354, 532 N.Y.S.2d at 139 (Balletta, J., dissenting). For a further discussion of this case, see infra note 67.

** See id. at 16, 516 N.Y.S.2d at 687-88. The only significant question unanswered in the Vogel case then was whether the evidence of the patient's desire to terminate the artificial nourishment was "clear and convincing." The court's reasoning enabled it to avoid that determination. In Chetta, the court had initially found that the evidence of the patient's previously expressed intent to refuse artificial life-sustaining treatment was clear and convincing, but upon reargument, under the guidance of Delio, the court determined that the evidence was in fact not clear and convincing. See Chetta, No. 1086/87, slip op. (Sup. Ct. Nassau County Feb. 26, 1988) (Becker, J.). Even when a permanently unconscious patient has not sufficiently expressed his or her competent desires, it is suggested that the New York courts allow either the family or guardian, or other health care decision-making agent, in conjunction with physicians, to infer from their intimate knowledge of the patient his or her likely treatment preferences, and to reach a decision on that basis regardless of the type of treatment involved.


** Id. at 270-74, 514 N.Y.S.2d at 894-96.
forego life-sustaining treatment if there were no hope of recovery. The \textit{Fink} decision, in so far as it denied authorization to discontinue intravenous feeding under the reasoning that discontinuance thereof would hasten death and thereby be the cause of death, would not pass muster under \textit{Delio} or the persuasive authority of \textit{Conroy}, which had expressly rejected the value and use of the distinction between actively hastening death and allowing death to naturally ensue.\footnote{Id. at 272-74, 514 N.Y.S.2d at 895-96. The apparent inconsistency in the decision resulted from the court's view that withdrawal of the intravenous feeding would hasten death and disturb the status quo, whereas performance of the gastrostomy would contradict the patient's previously expressed desires. See \textit{id.} at 273-74, 514 N.Y.S.2d at 895-96.} Notwithstanding the \textit{Delio} court's willingness to allow the withholding or withdrawal of artificial nourishment under specified circumstances, however, the issue remains unsettled in New York,\footnote{See \textit{In re Conroy}, 98 N.J. 321, 369, 486 A.2d 1209, 1233-34 (1985). See generally Brock, \textit{Forgoing Life-Sustaining Food and Water: Is It Killing?}, in \textit{By No Extraordinary Means} 117, 117-29 (J. Lynn ed. 1986) (discussing moral distinctions drawn between killing and allowing to die, and causing and not causing death). Moreover, only two months after the \textit{Fink} decision, and after the appellate decision in \textit{Delio}, the same court which decided \textit{Fink} was faced with another application seeking permission to refuse artificial feeding. See \textit{In re Strauss}, N.Y.L.J., July 30, 1987, at 12, col. 3 (Sup. Ct. Bronx County). Justice Tompkins, presiding again, explained that in \textit{Fink}, "[t]his Court distinguished between the failure to take extraordinary measures such as surgery and the ordinary provision of nutrients." \textit{Id.} However, the Justice felt obligated to adhere to the authority of \textit{Delio}, and upon finding "clear and convincing" evidence that the permanently unconscious patient would have refused artificial feeding, authorized the surrogate decision-makers to refuse "feeding by either intravenous or tubular means." \textit{Id.} at 12, col. 4. Justice Tompkins' determination is consonant with the \textit{Delio} court's rejection of the distinction between artificial feeding and other life-sustaining treatment, and properly focuses on the patient's right to refuse all life-sustaining treatment under the circumstances. See \textit{Delio}, 129 App. Div. 2d at 19, 516 N.Y.S.2d at 689.} at least until addressed by the New York Court of Appeals.\footnote{Daniel Delio died shortly after the appellate division's decision; consequently, no appeal was taken. \textit{Strauss}, N.Y.L.J., July 30, 1987, at 12, col. 4 n.3. This Article suggests that the court of appeals' prior decision, \textit{In re Storar}, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981), should not stand for the proposition that artifical feeding must not be withheld or withdrawn from a patient who is incapable of making treatment decisions and who did not sufficiently express his or her desire not to be kept alive through artificial means. In \textit{Storar}, the court of appeals refused to allow the mother of a terminally ill, never competent, profoundly retarded patient to order the withholding of life-sustaining blood transfusions. \textit{Id.} at 380-82, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-76. Rather than focusing on the fact that the patient was terminally ill, the court analogized blood transfusions to food and reasoned that such treatments could eliminate the risk of death from a treatable cause. \textit{Id.} at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275. That reasoning formed the basis for the court's denial of the patient's mother's request to discontinue the transfusions under the state's \textit{parens patriae} interest. See \textit{id.} at 380-81, 420 N.E.2d at 73, 438 N.Y.S.2d at 275-76. It is submitted that the court of appeals can best serve the interests of terminally ill patients by rejecting the \textit{Storar} court's implicit disapproval of the withholding or withdrawal of nourishment and by adopting the reasoning of the \textit{Delio} court that the proper focus should be on the patient and his desires regarding life-sustaining med-}
One commentator has argued that there are real and substantial differences between disconnecting a respirator and disconnecting a feeding tube. This commentator explains that, in contrast to the disconnection of a respirator, as in the Quinlan and Eichner cases, where the patient could live or die after disconnection, the disconnection of a feeding tube indubitably precipitates death "just as surely as if the doctor had shot the patient." The commentator further argues that in cases where an incompetent, terminally ill patient has not sufficiently made his desires known, the court should be willing to allow surrogate decision-making based on the patient's "best interests" or, if the patient is permanently unconscious, on the surrogate decision-maker's "best judgment" of the patient's preferences.

In August of 1988, the Appellate Division, Second Department, upheld the right of an incompetent seventy-seven year old patient, Mary O'Connor, to refuse nasogastric and intravenous feeding. In re Westchester County Medical Center, 139 App. Div. 2d 344, 345, 532 N.Y.S.2d 133, 133 (2d Dep't 1988). The appellate court upheld the lower court's finding that there was clear and convincing evidence that Ms. O'Connor, when competent, expressed a desire to refuse artificial life-sustaining treatment, which was held to include artificial feeding notwithstanding Ms. O'Connor's failure to articulate the specific type of life-sustaining treatments she would want withheld or withdrawn. Id. at 345, 532 N.Y.S.2d at 136. For further discussion of this case, see supra note 59.

While this Article was in print, the New York Court of Appeals reversed the decision reached by the appellate division in Westchester County Medical Center. See In re O'Connor, N.Y.L.J., Oct. 18, 1988, at 21, col. 3. The court of appeals confirmed the applicability of the "clear and convincing" evidence standard as enunciated in Eichner, and further elaborated that under this standard "nothing less than unequivocal proof will suffice when the decision to terminate life supports is at issue." Id. at 28, col. 5. Upon reviewing the record, the court held that there was not "clear and convincing proof that the patient had made a firm and settled commitment, while competent, to decline this type of medical assistance under circumstances such as these." Id. at 21, col. 4. Implicitly, the court recognized the propriety of withholding or withdrawing artificial feeding under proper circumstances. In addition, the court refused to adopt a substituted judgment approach and adhered to an inquiry limited to ascertaining and then effectuating the patient's expressed desires. Id. at 28, col. 6. The court stated:

That approach [substituted judgment] remains unacceptable because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another (People v. Eulo . . .). Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.

Id. Hence, as the court declared, the focus in New York "must always be on what the patient would say if asked today whether the treatment in issue should be terminated." Id. However, three of the seven judges believed that New York should recognize some procedure for addressing the withholding or withdrawal of artificial life-sustaining means for patients who cannot or have not adequately expressed their desires. Id. at 29, col. 4 (Simons, J., dissenting).

To the contrary, in instances where a patient requires an artificial feeding tube due to an inability to swallow, discontinuance thereof, like removal of a respirator from a patient unable to breathe spontaneously, "merely acquiesces in the natural cessation of a critical bodily function," and death arises because of the underlying medical problem, not the withdrawal.70

Another commentator has concluded that "[p]roviding artificial nourishment and hydration to a terminally ill comatose patient . . . should not be confused with providing food and water to a starving but otherwise well person."71 This distinction was evidently not recognized in the recent New York case, In re Brooks (Leguerrier).72 Brooks involved a petition by a nursing home seeking authority to force feed an elderly nursing home resident, who was considered capable of making health care decisions,73 either intravenously or through a nasogastric tube, because

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70 Id. at 891. The author further states that "[r]emoving a feeding tube is necessarily incompatible with the patient's survival. Food, unlike respiration, is never self-generating and must always come from a source outside the patient's own body. The disconnection of feeding tubes does not allow for alternative outcomes . . . ." Id. (footnotes omitted); see also Derr, supra note 41, at 28-29 (1986) (withholding or withdrawing food and fluids deemed "biologically final"); Meilaender, On Removing Food and Water: Against the Stream, 14 Hastings Center Rep. 11, 12 (1984) (patient will surely die without nourishment). What the author says is apparently unassailable. What the author fails to realize, however, is that in cases such as Peter and Delio, the court is not sanctioning death, even though death will ineluctably ensue. Rather, the court is attempting to effectuate the patient's desires and indelible right to refuse medical treatment under the circumstances. There is an ostensibly equal expectation that death will ensue upon removal of a respirator even though sometimes death is thwarted by the patient's spontaneous respiration.

71 Peter, 108 N.J. at 382, 529 A.2d at 428; see In re Gardner, 534 A.2d 947, 955-56 (Me. 1987); see also O'Rourke, The A.M.A. Statement on Tube Feeding: An Ethical Analysis, 155 Am. Med. 321, 322 (1986) (withholding artificial feeding permits "existing fatal pathology to take its natural course"). But see Barry, Facing Hard Cases: The Ethics of Assisted Feeding, 2 Issues in L. & Med. 99, 102-03 (1986) ("To bring a person to death, who is not at death's doorstep, by withdrawing food and fluids is to directly cause death and is not a case of allowing the person to die from an underlying pathological condition.").

72 Note, supra note 20, at 260-61.

73 No. 5805/87, slip op. (Sup. Ct. Albany County June 10, 1987) (Conway, J.); see also In re Plaza Health & Rehab. Center (Sup. Ct. Onandaga County Feb. 2, 1984) (Miller, J.) (denied petition of nursing home requesting authority to artificially feed competent nursing home patient who was neither terminally ill nor unable to eat). See generally Brock & Lynn, The Competent Patient Who Decides Not to Take Nutrition and Hydration, in By No Extraordinary Means 202 (J. Lynn, ed. 1986) (health care providers are not justified in seeking to force-feed competent and informed patients who elect to forego food and drink).

74 See Brooks, No. 5805/87, slip op. (Sup. Ct. Albany County June 10, 1987) (Conway, J.). The court evidently accepted the assessments of the attending physician and a social worker that the patient was rational and capable of making such a decision, although a psychiatrist believed otherwise. See id. The President's Commission had concluded that "'decisionmaking incapacity' rests on a judgment of the type that an informed layperson might make—that a patient lacks sufficient ability to understand a situation and to make a choice
she refused to eat or drink.\textsuperscript{74} The court denied the petition,\textsuperscript{75} yet the court’s decision lacked reasoned explication. The court merely cited New York’s leading cases and, without qualification, deemed itself bound by the “many decisions of the Court of Appeals” and “the recent decision of the Appellate Division [Delio].”\textsuperscript{76} Apparently, the court simply agreed with the patient’s guardian ad litem that the patient has an “absolute right as a competent, rational person to decide for herself what will be done to her body.”\textsuperscript{77} That right, however, is not absolute, but must be weighed against any potentially countervailing state interests.\textsuperscript{78} The court in \textit{Brooks}, nevertheless, did not weigh the potentially countervailing state interests against the patient’s right to refuse artificial nourishment.\textsuperscript{79}

The state’s interest in the preservation of life is usually considered the most significant of the state interests, but ordinarily it will not override a competent patient’s right to refuse medical treatment.\textsuperscript{80} According to the New Jersey Supreme Court, “the State’s interest . . . weakens and the individual’s right . . . grows as the degree of bodily invasion increases and the prognosis dims.”\textsuperscript{81} The \textit{Brooks} opinion did not indicate the patient’s prognosis, though it would have been a valid factor in the balancing process.

in light of that understanding.” \textsc{President’s Commission}, supra note 2, at 123. The New York State Task Force on Life and the Law had noted that “in recent years the notion of capacity to make health care decisions has emerged as an alternative to the traditional standard of competence.” \textsc{Task Force}, supra note 28, at 100. The Task Force contrasted “capacity” with “competence,” the latter generally referring to a judicial determination about a person’s ability to make decisions. See \textit{id}. On the other hand, “‘capacity’ is a more limited and specific concept; it refers to a person’s ability to make a particular decision as determined by health care professionals or others.” \textit{Id}. See \textsc{generally President’s Commission}, supra note 2, at 45, 121-26 (defining and discussing determination of decision-making capacity in context of decisions about life-sustaining treatment).

\textsuperscript{74} Brooks, No. 5805/87, slip op. (Sup. Ct. Albany County June 10, 1987) (Conway, J.).
\textsuperscript{75} \textit{Id}. The nursing home argued that as a Health Related Facility it had a duty under state law and administrative rules and regulations, see \textsc{N.Y. Pub. Health Law} art. 28 (McKinney 1985 & Supp. 1987); [1985] 10 \textsc{N.Y.C.R.R.} § 731.3(g), to provide requisite sustenance to patients entrusted to its care. \textit{Brooks}, No. 5805/87, slip op. (Sup. Ct. Albany County June 10, 1987) (Conway, J.). The nursing home further contended that state penal laws, see \textsc{N.Y. Penal Law} §§ 120.30, 125.15(3) (McKinney 1987), prohibited it from aiding or encouraging suicide. See \textit{Brooks}, No. 5805/87, slip op. (Sup. Ct. Albany County June 10, 1987) (Conway, J.). Finally, the nursing home contended that, although the court of appeals’ decisions recognize a patient’s right to refuse “extraordinary” life-sustaining treatment, such cases are inapplicable to “mere feeding to prevent a patient from committing suicide.” \textit{Id}.

\textsuperscript{76} \textit{Brooks}, No. 5805/87, slip op. (Sup. Ct. Albany County June 10, 1987) (Conway, J.).
\textsuperscript{77} \textit{Id}. (citations omitted).
\textsuperscript{78} See supra notes 15-16 and accompanying text.
\textsuperscript{79} See supra note 16 and accompanying text.
\textsuperscript{80} See, e.g., \textit{In re Conroy}, 98 \textsc{N.J.} 321, 349, 486 A.2d 1209, 1223 (1985).
\textsuperscript{81} \textit{In re Quinlan}, 70 \textsc{N.J.} 10, 41, 355 A.2d 647, 664, \textit{cert. denied}, 429 \textsc{U.S.} 922 (1976). Impliedly then, as the patient’s prognosis improves, the state’s interest strengthens.
The state's interest in the prevention of suicide, which is somewhat subsumed within the preservation of life interest, is another relevant interest clearly implicated by the Brooks case. It may be reasoned, however, that to refuse medical procedures in order to allow an illness to run its inevitable course is not suicide: death is caused by the underlying illness and not self-inflicted injury. The Brooks opinion did not specify whether the patient was suffering from any disease or infirmity. One inference which could be drawn is that the patient was not terminally ill. Patients with pathological complications that make it impossible for them to swallow and normally ingest food and water are readily distinguishable from patients capable of swallowing through their normal faculties. The latter precipitate the need for artificial feeding because of self-imposed restraints and not from underlying incapacities. The state's interest in preventing suicide becomes weightier, especially where the abstainer has been entrusted to the care of a nursing institution. Although it appears to be inconsistent with an institution's obligation to provide adequate nutrition to its patients, the Brooks court nevertheless upheld the right of a patient, quite capable of eating or drinking normally, to starve herself to death while remaining at the institution.

III. CATHOLIC MORAL THEOLOGY ON WITHHOLDING OR WITHDRAWING ARTIFICIAL NUTRITION AND HYDRATION

A. Interest of the Catholic Church

There are several reasons why the Catholic Church is interested in playing a role in public policy formulation regarding the issues involved in refusal of medical treatment cases. The following reasons are particularly significant: the interest of the Church in expressing Catholic theological perspectives where the issues implicate the disciplines of law, medicine, and religion; and the desire of the Church to safeguard and

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82 See Conroy, 98 N.J. at 350-51, 486 A.2d at 1224.
84 See Brooks, No. 5805/87, slip op. (Sup. Ct. Albany County June 10, 1987) (Conway, J.); see also Brock & Lynn, supra note 72 (patient capable of deciding to forego nutrition and hydration should be allowed).
preserve the moral and religious principles which guide health care facili-

ties operating under Catholic auspices, and which are affected by legisla-
tive and judicial determinations.88

88 See Brief and Appendix for Amicus Curiae, New Jersey Catholic Conference, at 1, In re
Brief]; see also
United States Catholic Church, Ethical and Religious Directives
for Catholic Health Facilities 2 (1971) [hereinafter Ethical
and Religious Directives] ("Any facility identified as Catholic assumes . . . the responsibility to reflect in its policies and practices
the moral teachings of the Church . . . . ").

In a recent New Jersey case, In re Requena, 213 N.J. Super. 475, 517 A.2d 886 (Ch.
Catholic religious order, was denied permission to compel the removal of a competent, ter-
minally ill elderly patient who, in contemplation of her loss of ability to swallow, anticipato-

rily refused artificial feeding. Id. at 447, 517 A.2d at 887. Despite the hospital's reaffirmation
of its policy against withholding food and water ("basic human needs"), and the willingness
of the hospital to assist in transferring the patient to a suitable institution, the court held
that under the circumstances the hospital's policy must yield to the patient's right to refuse
medical treatment notwithstanding the direct judicial interference with the hospital's policy.
Id. at 487-88, 517 A.2d at 892-93. Although a Catholic health care institution has legitimate
reason to be concerned over what it may perceive as judicial officiousness, the Requena
decision should be viewed as a limited exception to otherwise judicial reluctance to interfere
with hospital policy decisions. Because the patient, Ms. Requena, was not unconscious or
insensate, the court considered the possibility of emotional and psychological trauma to her
incident to a transfer of facilities. See id. at 480-81, 487, 517 A.2d at 889, 892-93. The trial
court found and was persuaded by the fact that Ms. Requena had developed a trust in and
affection for hospital personnel. See id. at 480-81, 487, 517 A.2d at 889, 893. The appellate
court was also influenced by the fact that the patient had become familiar with the sur-
roundings and personnel; moreover, it was persuaded by the fact that the patient had not
received adequate notice of the hospital's policy prior to her decision to refuse artificial
Thus, if the patient receives adequate notice of the hospital's policy of declining to honor
specified refusals of treatment, a court is less likely to view the hospital's decision as an
unreasonable interference with the patient's rights. Furthermore, where the patient is per-
manently unconscious there will be no need for the court to consider potential emotional
and psychological trauma to the patient incident to transfer and, in fact, courts have readily
deprecated to the moral and ethical prerogatives of health care institutions by not compelling
them to withdraw or withdraw treatment from permanently unconscious patients. See, e.g.,
(1986) (preservation of ethical integrity of hospital and its staff possible without infringing
on patient's right to refuse artificial nutrition and hydration); Delio v. Westchester County
Medical Center, 129 App. Div. 2d 1, 26, 516 N.Y.S.2d 677, 693 (2d Dep't 1987) (court's
directive drawn in alternative to allow medical center to either assist in or withdraw artifi-
cial nutrition and hydration or find suitable facility to do so). But see, e.g., In re Jobes, 108
N.J. 394, 424-26, 529 A.2d 434, 450 (1987) (nursing home could not refuse to participate in
withdrawal of artificial nutrition and hydration from patient whose family—surrogate deci-
sion-makers—had no notice of nursing home's asserted policy prior to decision to forego
treatment). See generally Annas, Transferring the Ethical Hot Potato, 17 Hastings Center
B. Withholding or Withdrawing Life-Sustaining Treatment

Catholic theology teaches that life is a gift from God, a fundamental though not absolute value, which each individual has a duty to preserve and make prosperous.\textsuperscript{86} Because life is not an absolute value, it need not be preserved under all circumstances; therefore, artificial life-sustaining measures may be withheld or withdrawn when morally justified.\textsuperscript{67} Traditionally, Catholic moral theology had applied an ordinary/extraordinary dichotomy when distinguishing morally obligatory (ordinary) from morally optional (extraordinary) life-preserving means.\textsuperscript{88} However, the distinction between ordinary and extraordinary means has not resulted in a systematic categorization of typical medical treatments by Catholic theologians, particularly because of rapid advances in medical technology.\textsuperscript{89} Moreover, it has been suggested that contemporary Catholic moral theology no longer necessitates recourse to these terms for justifying when particular life-preserving means may morally be withheld or withdrawn, and, instead, an analysis should be made in terms of “proportionate” and “disproportionate” means.\textsuperscript{90}


\textsuperscript{87} McCartney, supra note 86, at 38; see also McCormick, To Save or Let Die: The Dilemma of Modern Medicine, 229 J. A.M.A. 172, 174 (1974) (duty to preserve life is limited duty because life is a relative good); Walter, Food & Water: An Ethical Burden, 113 COMMONWEAL 616, 616 (1986) (“because life is not the highest good, it need not be preserved under all conditions”). The Catholic church does recognize a “right to die,” but only in the limited sense of a “right to die peacefully and in a manner worthy of a human being and a Christian.” Declaration on Euthanasia, supra note 86, at 294.

\textsuperscript{88} See D. McCarthy & E. Bayer, HANDBOOK ON CRITICAL LIFE ISSUES 161-62 (1982) [hereinafter Critical Life Issues]; President’s Commission, supra note 2, at 84 n.122; Walter, supra note 87, at 618; The Prolongation of Life, supra note 86, at 395-96.

The following ethical directive for Catholic Health Facilities embodies the traditional Catholic distinction: “Euthanasia (‘mercy killing’) in all its forms is forbidden. The failure to supply the ordinary means of preserving life is equivalent to euthanasia. However, neither the physician nor the patient is obliged to use extraordinary means.” ETHICAL AND RELIGIOUS DIRECTIVES, supra note 85, at 8. For a survey and discussion of the interpretation of the distinction between ordinary and extraordinary means drawn by early Catholic ethicists, see generally Kelly, The Duty of Using Artificial Means of Preserving Life, 11 THEOL. STUD. 203 (1950); McCartney, The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case, 47 LINACRE Q. 215 (1980).

\textsuperscript{89} See Declaration on Euthanasia, supra note 86, at 294.

\textsuperscript{90} See id. at 294; President’s Commission, supra note 2, at 88-89. The President’s Commis-
The contemporary approach of Catholic moral theologians regarding withholding or withdrawing artificial life-preserving means may be discerned from the analysis suggested by Father Gerald Kelly, S.J., a prominent Jesuit ethicist. Father Kelly proposed that artificial life-preserving means should not be considered morally obligatory if they do not offer a reasonable hope of benefit or cannot be obtained without excessive burden. Father Kelly's contemplation that Catholic moral theology espouse an assessment of the utility of the proposed means—its efficacy in achieving the desired results—and the proportionality of benefits and burdens is paralleled in the Vatican's latest pronouncement, its Declaration on Euthanasia. An interpretation of the Vatican's pronouncement reveals that when employing concepts of utility and proportionality in distinguishing whether the proposed treatment is obligatory or nonobligatory, the assessment must be from the patient's perspective and must consider the totality of the circumstances, including the interests of all affected.

91 See Kelly, supra note 88; Kelly, The Duty to Preserve Life, 12 THEOL. STUD. 550 (1951).
92 Kelly, supra note 91, at 550.
93 Declaration on Euthanasia, supra note 86, at 289-96. The Vatican proposed that treatment which is "not without risks or is excessively burdensome" is nonobligatory. Id. at 295. The Vatican explained that to withhold or withdraw "the application of medical techniques that are disproportionate to the value of the anticipated results" is morally justified, especially those treatments which "can only yield a precarious and painful prolongation of life." See id. Numerous other Catholic authorities and theologians have endorsed an analysis which embraces concepts of utility and proportionality. See U.S. Bishops' Committee for Pro-Life Activities, supra note 28, at 223 ("we recognize and defend a patient's right to refuse . . . means which provide no benefit or which involve too grave a burden"); Bayer, supra note 4, at 91 (not bound to prolong life by "impossible, substantially useless, or unreasonably burdensome" means); Connery, supra note 86, at 90 (can morally omit a means which is useless in prolonging life or excessively burdensome); McCartney, supra note 86, at 40 ("uselessness criterion must instantiate the burdensomeness doctrine and not be an independent justification in itself"); Paris, When Burdens of Feeding Outweigh Benefits, 16 HASTINGS CENTER REP. 30, 32 (1986) (means must offer "substantial hope of benefit" and burdens not disproportionate to benefits).
The significance of the foregoing analysis is that it reflects the traditional theological acceptance of the principle that even means which are relatively routine, non-invasive, inexpensive, and medically possible and available may be nonobligatory, if in the totality of the circumstances they would be futile or unreasonably burdensome to administer with respect to the particular patient. This writer suggests, therefore, that Catholic moral theologians avoid the terms "ordinary" and "extraordinary" when attempting to justify the morality of withholding or withdrawing artificial life-preserving means, and speak instead in terms of the utility of the proposed means—its efficacy in achieving the desired result—and the proportionality of benefits and burdens in the totality of the circumstances, all relative to the patient’s condition and prognosis.

See Declaration on Euthanasia, supra note 86, at 294. The Vatican declared that determining whether specific means may be withheld or withdrawn entails weighing "the type of treatment, its degree of difficulty and danger, its expense, and the possibility of applying it" against "the results that can be expected, all this in light of the sick person’s condition and resources of body and spirit." Id. at 294 (emphasis added). Father John J. Paris, S.J., explained that historically, moral theologians used the terms "ordinary" and "extraordinary" when referring to the patient’s condition, not the specific type of treatment or means. Paris, supra note 93, at 32; see also Walter, supra note 87, at 618 (distinction between "ordinary" and "extraordinary" means originally based upon "patient-centered" assessment of benefits and burdens). Father Paris contended that rapid advances in medical technology, unaccompanied by similar advances in moral theology, have led to a shift in the focus of the distinction from the patient and his condition to the type of means involved. See Paris, supra note 93, at 32. To some extent, this shift in focus could explain the position taken by those Catholic authorities and theologians who espouse the view that there is always a moral obligation to provide nutrition and hydration. See Walter, supra note 87, at 618. Papal pronouncements have clearly expressed that the assessment of benefits and burdens is to be made "according to the circumstances of persons, places, times, and culture" when determining if the means involved entail an excessive burden for the patient, family, or community. The Prolongation of Life, supra note 86, at 395-96; see Declaration on Euthanasia, supra note 86, at 295. One Catholic theologian, in summarizing his view of the contemporary Catholic position, proposed that it is morally acceptable to withhold or withdraw artificial life-sustaining means when "in the patient’s view, this intervention becomes physically, psychologically, economically, emotionally, or spiritually too difficult to bear [i.e., burdensome], either for the patient or others." McCartney, supra note 86, at 40 (emphasis added). Hence, a patient-oriented policy should not disregard the burdens befalling others, especially where the patient is permanently unconscious and probably unaware of temporal burdens, "but neither can it pretend that the patient himself is not also a center of value and a finality in the moral order." Meilaender, supra note 90, at 138. Thus, it is suggested that when surrogate decision-makers assess the benefits and burdens on the patient’s behalf, the assessment should be guided primarily by the patient’s values and beliefs.

See Paris, supra note 93, at 32; Paris & Varga, supra note 43, at 143. Father Kelly noted that a similar analysis had been espoused by an earlier theologian who viewed means as readily obtainable as food and water as nonobligatory if in the circumstances their use would be futile in prolonging life. See Kelly, supra note 88, at 208; see also Bayer, supra note 4, at 92 (moralists have long recognized that condemned man on death row need not eat “last meal” because food will not substantially prolong life).
C. The Morality of Withholding or Withdrawing Artificial Nutrition and Hydration

There is presently a conflict among Catholic authorities and theologians over the morality of allowing a patient to forego artificial nutrition and hydration. The following discussion will present and analyze cont-

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See Paris & McCormick, The Catholic Tradition on the Use of Nutrition and Fluids, 156 AM. 356, 361 (1987). Fathers John J. Paris, S.J., and Richard A. McCormick, S.J., have contended that neither traditional nor contemporary Catholic moral theology calls for a distinction based on the means sought to be withheld or withdrawn; they believe that it is moral to withhold food and water, artificial or otherwise, when appropriate under a utility and proportionality analysis. See id. at 358; see also Bayer, supra note 4, at 97 (society must allow withdrawal of food and water when useless to substantially prolong life or when excessively burdensome); Lynn & Childress, supra note 41, at 18-19 (artificial nutrition and hydration should be foregone if excessively burdensome, futile, or of no benefit); McCartney, supra note 86, at 40 (Catholic teaching not opposed to withholding artificial sustenance if burdensome, and uselessness should be factor in determining burdensomeness); O'Rourke, supra note 70, at 322 (can withhold or withdraw tube feeding “[i]f efforts to prolong life are useless or result in a severe burden for the patient” in his pursuit of purpose of life); Walter, supra note 87, at 619 (no moral distinction between refusal or withdrawal of nutrients and other medical technologies such as respirator). In addition, neither the Vatican nor the U.S. Bishops' Committee for Pro-Life Activities condemns the morality of withholding or withdrawing artificial nourishment under all circumstances. See Declaration on Euthanasia, supra note 86, at 294-95 (drawing no distinction as to type of treatment, but rather, relying on determination of benefits and burdens); U.S. Bishops' Committee for Pro-Life Activities, supra note 28, at 224 (artificial nourishment may become “too ineffective or burdensome to be obligatory;” nevertheless, there should be presumption favoring its use).

On the other hand, the New Jersey Catholic Conference has maintained that “nutrition and hydration, which are basic to human life, and as such distinguished from medical treatment, should always be provided to a patient. Withdrawal of nutrition and hydration introduces a new attack upon human life.” Amicus Brief, supra note 85, at 2-3; see also Pontifical Academy of Sciences, The Artificial Prolongation of Life, in 15 ORIGINS 415, 415 (1985). Under the auspices of the Pontifical Academy of Sciences, a group of doctors and scientists reported to Pope John Paul II that, although medical intervention may not be required for a permanently unconscious patient or any patient for whom treatment is of no benefit, “all care should be lavished on him, including feeding.” Id. (emphasis added); see also Barry, supra note 70, at 100-01 (1986). Father Robert Barry, O.P., maintains that artificial means of nutrition and hydration, except hyperalimentation, are not medical treatments, because they are consistent with normal basic care providing “natural extrinsic resources of the body” that do not “[d]irectly, proximately, and immediately” cure pathological conditions. Id.; see Meilaender, supra note 69, at 11-12 (nourishment is not a cure in itself, but care that humans owe one another to sustain life); see also Derr, Why Food and Fluids Can Never Be Denied, 16 HASTINGS CENTER REP. 28, 28-30 (1986) (“six mutually reinforcing . . . considerations” distinguish food and fluids from medical treatment). Father Barry contends that intravenous, nasogastric, or stomach tube feeding should be implemented whenever it can sustain life and is medically possible to implement, and rejects the proposition that these means could be excessively burdensome or that their financial burden could justify withdrawal. See Barry, supra note 70, at 103-04; see also Amicus Brief, supra note 85, at 5 (provision of nutrition and hydration is not excessively burdensome and should always be provided).
temporary Catholic moral theology regarding the withholding or withdrawal of artificial nutrition and hydration from terminally ill and permanently unconscious patients.

In regard to permanently unconscious patients, an analysis of the utility of providing artificial nutrition and hydration to prolong life raises an insoluble philosophic dilemma. If it is assumed, \textit{arguendo}, that the permanently unconscious patient is not a “dying patient,” is feeding the patient useful simply because it prolongs the life (or existence) of the patient? According to the U.S. Bishops’ Committee for Pro-Life Activities, nutrition and hydration are not useless when they can sustain the patient’s life regardless of the patient’s condition.\footnote{See U.S. Bishops’ Committee for Pro-Life Activities, \textit{supra} note 28, at 223.} Similarly, the New Jersey Catholic Conference has asserted that “there is no dispute that nutrition and hydration are beneficial because they would preserve the permanently unconscious patient’s life.”\footnote{See Amicus Brief, \textit{supra} note 85, at 8.} Gilbert Meilaender, Professor of Religion, Oberlin College, has suggested that, notwithstanding the fact that artificial feeding is not implemented primarily to cure or to retrieve the cognitive capabilities of the now insensate patient, such treatment is useful because it constitutes needed care that ought not be foregone.\footnote{See \textit{Meilaender}, \textit{supra} note 69, at 12-13; Meilaender, \textit{supra} note 90, at 139; see also \textit{Barry}, \textit{supra} note 70, at 105 (artificial feeding is useful in sustaining “natural organic operations and defenses” even if not principally aimed at improving neurological functions); \textit{Connery}, \textit{supra} note 86, at 90, 95 (not useless if it prolongs life perceptibly, and human life is present at least until brain death).} Conversely, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has determined that providing nutrition and hydration to a permanently unconscious patient is essentially useless, except to the extent that sustaining the body permits the remotest chance of recovery.\footnote{See \textit{PRESIDENT’S COMMISSION}, \textit{supra} note 2, at 190.} According to one Catholic ethicist, Father Kevin O’Rourke, O.P., providing artificial nutrition and hydration is useless if it is unable to restore “cognitive-effective function” to the permanently unconscious patient.\footnote{See \textit{O’Rourke}, \textit{supra} note 70, at 322.} Father O’Rourke’s conclusion was premised on the proposition that physiological existence without cognitive capacity negates the patient’s attainment of the purposes of life.\footnote{See \textit{id.}; see also \textit{Bayer}, \textit{supra} note 4, at 92-93 (permanently unconscious patient has lost that capacity which identifies one as human being: the capacity for human intercommunication); \textit{Lynn & Childress}, \textit{supra} note 41, at 18 (food and water are useless to patient who will never be able to experience events occurring in world or in his own body). \textit{But see Barry}, \textit{supra} note 70, at 105 (food and water should not be considered useless if they can sustain life); \textit{Meilaender}, \textit{supra} note 69, at 12 (not useless if it preserves bodily life, even if it does not restore cognitive capacity).}
What about the usefulness of providing artificial nutrition and hydration to a patient who is literally “dying”—the terminally ill patient? In discussing the morality of withholding artificial feeding from a terminally ill patient, Father Kelly posed a hypothetical involving a conscious, terminally ill patient in excruciating pain whose life could be prolonged several weeks with intravenous feeding. Father Kelly responded that, in theory, the patient’s relatives should be able to refuse the feeding because it would be useless under the circumstances. Father Joseph V. Sullivan, addressing an almost identical scenario (a terminally ill cancer patient suffering extreme pain), upheld a physician’s choice to withdraw intravenous feeding, deeming it nonobligatory because of the patient’s condition.

Doctors Joanne Lynn, M.D., former Assistant Director of the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, and James F. Childress, Ph.D., Professor of Religious Studies and Medical Education, University of Virginia, in their highly authoritative and persuasive article, discussed hypothetical situations involving a variety of terminally ill patients to illustrate the futility of providing food and water under some circumstances. Most significantly, the Vatican explicitly addressed the plight of the terminally ill in its Declaration on Euthanasia, and clearly counselled the morality of foregoing those treatments incapable of preventing death and only yielding a “precarious and painful prolongation of life.” It is submitted that the Vatican had no intention of excluding artificial nutrition and hydration from the myriad of life-sustaining treatments that could properly be withheld or withdrawn from

103 Kelly, supra note 88, at 218-19.
104 See id. at 219. However, Father Kelly declined to give a definitive response because he feared that withholding feeding under such circumstances would be perceived as a form of “Catholic euthanasia.” See id. His fear was based on his position that the intravenous feeding should be considered “ordinary,” but nevertheless optional, because it was useless under the circumstances; that position may have been unacceptable to his contemporaries, since the distinction between omitting an “ordinary” means as opposed to a “useless ordinary” means may not have been appreciated. Id. Fathers Paris and McCormick have suggested that Father Kelly's reluctance to counsel physicians that withholding intravenous feeding can be morally permissible may have given impetus to the view of some moralists that feeding must always be provided. See Paris & McCormick, supra note 96, at 360. It is noteworthy, however, that Father Kelly later altered his position when he explained that the uselessness of a given means indicates it is “extraordinary” and, hence, clearly optional. See Kelly, supra note 91, at 550.
105 See McCartney, supra note 86, at 38 (quoting J. Sullivan, Catholic Teaching on the Morality of Euthanasia 73 (1949)).
106 See Lynn & Childress, supra note 41, at 18. The authors explained that such futile efforts may in fact cause further suffering without countervailing benefits. Id.
107 See Declaration on Euthanasia, supra note 86, at 295.
terminally ill patients.108

Deciding whether feeding the terminally ill and permanently unconscious is useful or useless is actually subsumed within the analysis of the proportionality of benefits and burdens.109 If the physician’s conclusion that the patient has no hope of recovery and the determination that a permanently unconscious patient can no longer derive any benefit from feeding are accepted,110 then the feeding should be considered futile and the burdens disproportionate to the benefits; thus, the artificial feeding would be deemed morally nonobligatory under Catholic precepts.111 With respect to terminally ill patients who are incapable of deciding their course of treatment and who will soon die regardless of any medical interventions, efforts to nourish will, to a great extent, be futile; therefore, the morality of foregoing nourishment should stem from an appraisal of the patient’s comfort needs in terms of benefits and burdens.112 Feeding could then be foregone if excessively burdensome at this stage in the dying process.

The New Jersey Catholic Conference has maintained that providing

108 See Address by Joseph Cardinal Bernardin, Archbishop of Chicago and Chairman of the National Conference of Catholic Bishops’ Committee for Pro-Life Activities, at the University of Chicago’s Center for Clinical Medical Ethics (May 26, 1988) [hereinafter Address by Joseph Cardinal Bernardin] (“We also may not develop a policy to keep alive those who... are terminally ill, or to preclude a decision... that the artificial provision of nutrition and hydration has become useless or unduly burdensome.”). The Vatican, however, did express the caveat that “ordinary treatment that is due to the sick in such cases may not be interrupted.” Declaration on Euthanasia, supra note 86, at 295. It is submitted that the Vatican was referring to comfort care, both spiritual and physical, necessary to ease the dying process. See O’Rourke, supra note 70, at 323; see also Unif. Rights of the Terminally Ill Act § 6(b) (Proposed Official Draft by the National Conference of Commissioners on Uniform State Laws, 1985) (Act does not affect physician’s obligation to provide nutrition and hydration for comfort care or relief of pain); Cranford, Patients With Permanent Loss of Consciousness, in BY NO EXTRAORDINARY MEANS 186, 188 (J. Lynn ed. 1986) (overriding objective is not to prolong life, but to maintain comfort, hygiene, and dignity); Lynn & Childress, supra note 41, at 19 (food and fluids may be warranted as palliative care). A group of ten physicians, co-authors of a highly publicized article, went further, and concluded that if “severely and irreversibly demented” patients (not necessarily terminally ill) refuse oral nutrition, artificial nutrition and hydration may then be withheld: the only care necessary would be that needed to make them comfortable. See Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, The Physician’s Responsibility Toward Hopelessly Ill Patients, 310 New Eng. J. Med. 955, 959 (1984). The justification for withholding feeding to this type of patient is not, however, that it is useless, but that it may be excessively burdensome. See Meilaender, supra note 69, at 13.

109 See McCartney, supra note 86, at 40.

110 See Lynn & Childress, supra note 41, at 18; supra notes 101-02 and accompanying text.


112 See supra notes 107-08 and accompanying text.
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nutrition and hydration is never excessively burdensome and, therefore, always obligatory.\textsuperscript{113} However, this view is contested in contemporary Catholic moral theology.\textsuperscript{114} Three issues have contributed to this disagreement. First, should an assessment of burdens be limited to the burdens of the treatment itself or include the burdens of the life sustained? Second, is the burden to others—other than the patient—relevant? Third, is the economic burden a relevant consideration?\textsuperscript{116}

The burdens of the artificial feeding itself, the actual intrusion and risk incident to the initial implementation and continuing provision, are obvious considerations.\textsuperscript{118} However, it has been argued that to limit an assessment of burdens to the treatment itself would foreclose a determination of the burdens of the life sustained, that is, the patient's "quality of life" with the treatment.\textsuperscript{117} It has been further argued that in determining the patient's "quality of life," the quality of the patient's life should be discerned from the patient's point of view and not from another's point of view as to what is an appropriate quality of life for that patient.\textsuperscript{118} Father James McCartney, O.S.A., has stated that Catholic

\textsuperscript{113} See Amicus Brief, supra note 85, at 5; see also Barry, supra note 70, at 104-05 (intravenous, nasogastric, and stomach tube feeding are not excessively burdensome in the long term).

\textsuperscript{114} See Paris & McCormick, supra note 96, at 360.

\textsuperscript{115} See President's Commission, supra note 2, at 85 n.123.

\textsuperscript{116} See Lo & Dornbrand, supra note 41, at 403; Lynn & Childress, supra note 41, at 18; Major, supra note 3, at 24-27.

\textsuperscript{117} Walter, supra note 87, at 618-19; see O'Rourke, supra note 70, at 323.

\textsuperscript{118} See, e.g., Walter, supra note 87, at 619. James Walter, Associate Professor of Theology, Loyola University, Chicago, observed that if Catholic ethicists recognize that "'quality of life' stands for a certain norm or criterion which states that a person's life is not worth anything unless that life is able to function at an arbitrary level" then the judgment is indeed improper. \textit{Id.} That sentiment was the essence of the New Jersey Supreme Court's refusal to allow a determination of a patient's "best interests" based upon the "'social utility'... or the value of that life to others." \textit{In re Conroy}, 98 N.J. 321, 367, 486 A.2d 1209, 1232-33 (1985). Professor Walter explained that a "'quality of life' determination can be interpreted in such a way as to reflect an inquiry into the "'quality' of a person's life as it affects his or her ability to pursue and attain values beyond biological existence." Walter, supra note 87, at 619; see also O'Rourke, supra note 70, at 323 (relevant burden for terminally ill is "the burden that a person would experience in striving for the purpose of life, not the burden associated with the means to prolong life"). \textit{But see} Connery, supra note 86, at 92-94. Father John Connery, S.J., S.T.D., does not believe it is possible to delineate a morally acceptable "'quality of life' criterion once one attempts to pass the confines of a quality of treatment assessment. See \textit{id.} at 94; Derr, supra note 41, at 36-37 (one must not judge as to burdensomeness of patients' lives). Father Connery's conclusion is premised on the belief that allowing judgments as to the quality of patients' lives puts society "at the edge of the slippery slope toward euthanasia." Walter, supra note 87, at 616. The U.S. Bishops' Committee for Pro-Life Activities has urged for legally established safeguards to protect unconscious and otherwise disabled patients from adverse judgments concerning their quality of life. \textit{See} U.S. Bishops' Committee for Pro-Life Activities, supra note 28, at 224.
teaching recognizes the propriety of assessing burdensomeness from the patient’s perspective “in terms of the physical, economic, psychological, or spiritual factors involved.”

Regarding the burden to others, Papal pronouncements clearly espouse the propriety of considering the burden to others when determining whether excessive burdens render the treatment nonobligatory. The Vatican’s Declaration on Euthanasia explicitly recognized that a “heavy burden on the family or community” indicates the treatment might be excessively burdensome. As to the third controversial issue, the relevancy of economic burdens, significant authority indicates that economic costs are pertinent and proper considerations in the assessment of burdens.

In several respects, a resolution of the conflict in contemporary Catholic theology on the morality of withholding or withdrawing artificial nutrition and hydration under certain circumstances from patients incapable of making health care decisions should lend significant authoritative guidance to courts, health care providers, and health care decision-makers. First, courts have recognized the value of the evidence of a patient’s religious beliefs and the tenets of that religion which, if clear, may significantly aid the decision-maker in discerning the now incompetent patient’s desires regarding life-sustaining treatment. In turn, if the patient’s desires are sufficiently known they will be paramount in directing the course of treatment. Second, Catholic related health facilities, guided by the precepts of the Catholic Church, could unhesitantly fulfill their role of conscientiously serving the health care needs and desires of terminally ill and permanently unconscious patients, while faithfully adhering to Catholic moral precepts. Catholic-related health facilities would have little need to resort to the courts when resolving requests to with-
hold or withdraw artificial feeding. Third, when courts are faced with articulating the relevant factors to be considered in weighing the benefits and burdens involved in withholding or withdrawing artificial nourishment, Catholic teaching could persuade the courts that, contrary to the New Jersey Supreme Court's focus on pain as the dispositive criterion for deciding the best interests of a terminally ill patient, an analysis of the relevant burdens entails a broader assessment.

IV. Conclusion

Recent case law has significantly bolstered judicial acceptance of a patient's right to refuse artificial nutrition and hydration by finding these measures indistinguishable from other forms of life-sustaining medical treatment such as a respirator. If courts would uniformly accept or reject the proposition that artificial nutrition and hydration may be foregone, they could engage in the resolution of other significant issues, including the establishment of safeguards in the health care decision-making process where legislative efforts do not exist.

A Vatican pronouncement of the Catholic Church's position on the morality of withholding or withdrawing artificial nutrition and hydration under certain circumstances would eliminate the confusion now troubling Catholic authorities and theologians and, simultaneously, would lend guidance to health care providers and decision-makers within and without the Catholic community. Additionally, clarification of the Church's
position should further the efforts of surrogate decision-makers (whether the courts or private parties) when they attempt to discern the previously expressed desires of patients who are now incapable of making health care decisions, especially where the patient's closely held religious beliefs are those espoused by the Catholic Church.\textsuperscript{129}

\textsuperscript{129} See supra note 30 and accompanying text.