NOTE

In re Quinlan Revisited: The Judicial Role in Protecting the Privacy Right of Dying Incompetents*

Introduction

Twelve years after the New Jersey Supreme Court's landmark *In re Quinlan*[1] decision, the legally and morally perplexing question of who decides[2] whether to forego life sustaining treatment[3] for irreversibly in-

---

* This Note is dedicated in fond remembrance to Professor Paul Ramsey, late professor emeritus of Christian ethics at Princeton University. Professor Ramsey was a vigorous champion of the dignity and rights of the vulnerable ill and dying.

1. 70 N.J.10, 355 A.2d 647 (1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

2. This Note focuses on the court's role in adjudicating treatment decisions for the irreversibly incompetent patient. An ancillary, but equally important issue is whether the problem of deciding the dying incompetent's treatment is a fundamentally medical or legal dilemma. If a treatment decision presents essentially a question of medical judgment, some have argued that the courts generally are not needed to oversee physicians' exercise of medical discretion. *See, e.g., In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 75-76 (1981) (Jones, J., dissenting in part); *see also* John F. Kennedy Memorial Hospital v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) (in consultation with family members, doctors are in the best position to make these decisions regarding the termination of treatment for dying incompetents). Under this approach, a proper member of the patient's family may approve a physician's decision to end treatment or to forego efforts at resuscitation without formal legal process. *Id. See also In re* Guardianship of Grant, 109 Wash. 2d 545, 567, 747 P.2d 445, 456 (1987). Others assert that only the patient in consultation with her attending physician has the legal right to make significant medical decisions. *See In re* Conroy, 98 N.J. 321, 347, 486 A.2d 1209, 1222 (1985) (the doctor's role is to provide the necessary medical facts and the patient's role is to make a decision regarding treatment based on his understanding of those facts). According to this view, a surrogate decision-maker must petition the court for permission to terminate treatment of a dying incompetent patient. For a discussion of the conflicts between these medical and legal frames of reference, see Note, *Decisionmaking for the Incompetent Terminally Ill Patient: A Compromise in a Solution Eliminates A Compromise of Patients' Rights*, 57 IND. L.J. 325 (1982). Under either the medical or legal approach courts must ultimately establish "appropriate constraints" on this type of decision-making to protect patients' interests in controlling their own lives. *In re* Conroy, 98 N.J. 321, 345-46, 486 A.2d 1209, 1221 (1985). *Accord, Superintendant of Belchertown State School v. Saikewicz*, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977) ("Such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."). *Cf. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied sub nom.* Storar v. Storar, 454 U.S. 858 (1981). Judge Jones, dissenting in part in *Storar*, questioned the

competent, dying patients[4] continues to vex and divide the courts. In *Quinlan*, the court held that a trustworthy loved one could assert the patient's constitutional right to privacy to support a request, in the patient's name, to withdraw life prolonging treatment.[5] However, the court's bold innovation of judicially authorizing a trusted, intimate surrogate to resolve the question unguided by the patient's expressed preference remains an insight in search of a rationale. The *New York Times* recently observed the medical dilemma underlying the problem when it noted that medical science has expanded doctors' ability to sustain life faster than their ability to restore health.[6]

Although the United States Supreme Court has not yet addressed the question, several state high courts considering patients whose treat-

---

presumed superior competence of the judiciary to make decisions to forego or terminate life support, noting that many such treatment choices were made routinely by doctors and families without judicial involvement: "The problem [of deciding whether to forego life support] is one which the judicial system is unsuited and ill-equipped to solve and which should not usually be made the subject of judicial attention." *Id.* at 385, 420 N.E.2d at 75. Judge Jones acknowledged, however, that "there will be occasions in which the courts will have [these cases] thrust on them." *Id.* at 386, 420 N.E. at 76. Given the inability of the patient himself to direct the treatment decision in *Storar*, Judge Jones endorsed deference to the patient's mother, whose decision appeared consistent with an objective weighing of the medical factors involved. *Id* at 391, 420 N.E.2d at 79. Private parties may also bring uncontested matters to court, either to avoid future liability by obtaining court approval, or to comply with statutory requirements as guardians of the incompetent. *See, e.g., In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976); Brophy v. New England Sinai Hospital, 398 Mass. 417, 497 N.E. 2d 626 (1986) (declaratory judgments sought by close family members to establish right to end patient's life sustaining treatment); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) (guardian petitioned court for permission to terminate life support).

3. The phrase "foregoing life sustaining treatment" refers to *withholding* initiation of such treatment as well as *withdrawing* treatment once it has commenced. *See generally* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983) [hereinafter PRESIDENT'S COMM'N].

4. An "incompetent" patient lacks either the mental capacity to understand her medical condition or the physical capacity to communicate her preferences. *See Conroy*, 98 N.J. at 360, 486 A.2d at 1229 ("[T]he condition of an incompetent patient makes it impossible to ascertain definitively his present desires."). Incompetence may result from sudden or gradual brain damage that leads to coma, permanent loss of consciousness, or severe dementia.

Defining the term "dying" has itself become problematic. The dictionary definition, "about to die," WEBSTER'S NEW WORLD DICTIONARY 436 (2d College ed. 1976), clearly applies when a patient's physical condition is rapidly and irreversibly deteriorating. In other cases, however, technology may make possible a prolonged period of survival without recovery. In such a situation, physicians and jurists consider the patient to be "dying" not because death is imminent, but because recovery to a sapient or even sentient state is extremely unlikely. *See* Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 at 1344 (Del. Supr. 1980) ("[W]e are on the threshold of new terrain—the penumbra where death begins but life, in some form, continues."). For a discussion of the problems that arise because of the vagueness of the term "dying", see G. GRISEZ & J. BOYLE, JR., LIFE AND DEATH WITH LIBERTY AND JUSTICE 59-85 (1979) [hereinafter GRISEZ & BOYLE].

5. 70 N.J. at 38-42, 355 A.2d at 6.

6. N.Y. Times, Sept. 12, 1986, at 10, col. 5.

ment preferences are readily ascertainable have adopted *Quinlan*'s reliance on the patient's federal constitutional right to privacy[7] to control her own medical care. Some courts rely additionally or exclusively on the common law right of self determination[8] to assure that the patient retains control over treatment decisions where the patient's preference is clear.[9] The issues presented in *Quinlan*, however, differ significantly from those presented when the incompetent patient has earlier expressed a clear view regarding such treatment. When the courts cannot determine the patient's preference, they must rely on the common law doctrine of *parens patriae*[10] to decide in the patient's "best interest" whether to withdraw life prolonging treatment. Courts frequently diverge in their standards for defining the patient's "best interest."[11] This variance results from a general lack of legislative guidance in these "no expressed preference" cases[12] and the inherently fact-sensitive, equitable nature of such decisions.[13] Although the "no expressed preference" patient is consistently held to enjoy the same right of self determination as competent

7. Although the Constitution contains no explicit reference to the right to privacy, the United States Supreme Court has held that certain textual constitutional rights imply this right. *See infra* notes 58-62 and accompanying text. *See In re* Guardianship of Grant, 109 Wash.2d 545, 554, 747 P.2d 445, 449 (1987); Brophy v. New England Sinai Hospital, 398 Mass. 417, 430-31, 497 N.E.2d 626, 633-34 (1986); *In re* Conroy, 98 N.J. 321, 347-349, 486 A.2d 1209, 1222-23 (1985); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So.2d 921, 924 (Fla. 1984); *In re* Torres, 357 N.W. 2d 332, 339 (Minn. 1984); *In re* Colyer, 99 Wash.2d 114, 660 P.2d 738 (1983); Satz v. Perlmutter, 379 So.2d 359 (Fla. 1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

8. The right of self determination refers to the individual's right to control her own body, including medical treatment. *See infra* notes 20-30 and accompanying text.

9. *See* cases cited in note 7, *supra*. *See also* Eichner v. Dillon, 52 N.Y. 2d 363, 376, 420 N.E. 2d 64, 70 (1981).

10. Literally, "parent of the country." This doctrine provides "that all orphans, dependent children, and incompetent persons, are within the special protection, and under the control, of the state." BALLENTINE'S LAW DICTIONARY 911 (3d ed. 1969). *See infra* note 34 and accompanying text.

11. *See infra* notes 50-57 and accompanying text.

12. *Conroy*, 98 N.J. at 344, 486 A.2d at 1220-21; *In re* Hamlin, 102 Wash. 2d 810, 821-22, 689 P.2d 1372, 1378 (1984); Barber v. Superior Court, 147 Cal. App. 3d 1006, 1014, 195 Cal.Rptr. 484, 488-89 (1983); Satz v. Perlmutter, 379 So.2d 359, 360 (Fla. 1980) (calling for legislative guidance in the management of treatment termination decisions for dying incompetent patients). While state legislatures have at times explicitly provided procedures by which incompetent adults may clarify their treatment preferences under the circumstances of dying incompetency, such statutes often do not explicitly cover the case of the "no expressed preference" patient, *see Grant*, 109 Wash. 2d at 564-65, 747 P. 2d at 455 (majority's view) and *id.* at 575-80, 747 P.2d 460-63 (Goodloe, J., dissenting) (dissent's view). *See also infra note* 17.

For convenience, the term "no expressed preference" refers to dying incompetent patients who, prior to their incompetency, had not clearly and reliably expressed their preference on the question of whether life sustaining treatment should be withheld.

13. At least one court has openly expressed its apprehension in dealing with this highly sensitive issue: "We thus approach this case with caution, conscious that life-and-death deci-

patients and patients who have made their views clear, use of the "best interest" method of surrogate decision-making may result in a decision contrary to the patient's wishes.[14] When the court disregards compelling but evidentially defective indications of the patient's wishes, the best interest test may eliminate any personal influence by the patient on the decision to terminate treatment.[15]

This Note argues that the dilemma faced by courts charged with upholding the common law doctrines of both self determination and *parens patriae* can be resolved in some cases by a privacy right rationale. Expanding on *Quinlan*, the Note offers a more developed analysis of the applicability of the privacy right to this policy conflict. Part I examines the courts' reliance on the common law doctrines of self determination and *parens patriae* to decide medical treatment questions. Part II explores the *Quinlan* case and relates the constitutional right to privacy to the circumstances of "no expressed preference" patients who have a trustworthy intimate to serve as surrogate decision-maker. Part III applies this privacy right rationale to two recent cases in which courts employed different types of best interest tests on behalf of "no expressed preference" patients. This Note concludes that neither the common law right of self determination nor a best interest test adequately protects the dying incompetent's privacy interest when the patient has not previously expressed a clear preference as to treatment decisions. It advocates instead the sound and humane policy advanced by the ruling in *Quinlan*, which favors putting the decision in the hands of a trustworthy intimate of the dying incompetent. The court's use of the privacy right in *Quinlan* did not merely provide constitutional stature to the right of self determination; it expanded the law's protection of a patient's privacy beyond that offered by the self determination right.

I. Common Law Background

The question whether to forego life support arises when a patient lacks the competence to understand and evaluate her condition and to decide whether to continue noncurative, life prolonging treatment.[16] In

sions like these are an awesome responsibility that can be undertaken only with a profound sense of humility and reserve." *Conroy*, 98 N.J. at 343-44, 486 A.2d at 1220.

14. *See infra* text accompanying and following notes 50-51.

15. *See infra* text accompanying notes 52-57.

16. Some commentators reject this question from the outset, asserting that the state interest in preserving life should control in all situations where the patient herself does not explicitly and competently refuse the life sustaining treatment. J. NOWAK, R. ROTUNDA & J. N. YOUNG, CONSTITUTIONAL LAW (3d ed. 1986) 720-21 [hereinafter NOWAK, ROTUNDA, & YOUNG]. This view has been criticized for several reasons. First, competent patients, confronted with expensive, often painful life support without hope of recovery, have increasingly elected to forego life support, calling into question the accuracy of the legal presumption that the incompetent patient, if competent, would favor continued treatment. PRESIDENT'S COMM'N, *supra* note 3 at 240. Second, the common law right of competent patients to control

these cases someone other than the patient must decide whether to forego treatment. The method chosen for surrogate decision-making depends on whether the patient has expressed a clear preference prior to becoming incompetent.

Three different scenarios arise in which a patient must rely on a surrogate. First, the dying patient, during an earlier period of competency, may have clearly and reliably expressed a preference as to whether she would wish physicians to continue artificial life support in the event of her incompetency.[17] Second, dying infants or mentally retarded persons always require surrogate decision-makers because courts deem these persons incompetent even before the onset of physical disability.[18] Third,

---

their medical treatment, even if their choice hastens death from their disease, has been strengthened by increased legislative action and judicial confirmation. *See* Note, PROXY DECISIONMAKING FOR THE TERMINALLY ILL: THE VIRGINIA APPROACH, 70 VA. L. REV. 1269 (1984). This recent policymaking suggests a shift away from a presumption that a dying patient necessarily prefers to sustain life at any cost. *See* GRISEZ AND BOYLE, *supra* note 4, at 269-70 ("If a noncompetent person is dying and permanently unconscious, then the reasonable presumption is that the medical care to prolong life is innapropriate, since most people would find care under such conditions psychologically repugnant and inconsiderate of others."). Third, the courts generally apply an analysis based on the choices of competent patients to the circumstances of dying incompetent patients, especially where an incompetent patient has expressed a clear preference on the life support question. *See, e.g.*, cases cited in note 7, *supra*.

17. *See, e.g.*, Eichner v. Dillon, 52 N.Y. 2d 363, 420 N.E.2d 64 (1981) (patient's preference should control where the patient, having fallen into an irreversible coma, had earlier clearly expressed the desire that life support be ended if his condition indicated no chance of recovery). A "living will," "a physician's directive" under a "natural death" statute, and a "durable power of attorney for health care" provide different degrees of statutory authority for enforcing the patient's preferences expressed in such documents. A living will is an "instrument executed with the formalities necessary for a valid will, expressing an intention to refuse treatment and release medical personnel from all liability should the declarant become terminally ill and incapable of asserting the right to refuse treatment. Ufford, Brain Death/Termination of Heroic Efforts to Save Life—Who Decides?, 19 Washburn L.J. 225, 247 (1980). Living wills are generally not legally enforceable without enabling legislation. Note, *The California Natural Death Act: An Empirical Study of Physicians' Practices*, 31 STAN. L. REV. 913, 917 (1979).

Natural death acts provide a statutory form by which a patient directs his physicians to forego artificial life support under certain circumstances without civil or criminal liability. *See, e.g.*, Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1988). For a discussion of the strengths and weaknesses of a natural death act which also provides for living wills, see Note, Proxy Decisionmaking, *supra* 1272-1302. A durable power of attorney for health cases is a statutory form authorizing a patient's agent, as "attorney in fact," to make health care decisions for the patient as principal, under certain circumstances, after the patient has become incompetent. *See, e.g.*, Cal. Civil Code §§ 2430-2444 (West Supp. 1988). Because these devices are either absent or ineffective in the case of the patient who has expressed no clear preference, they are not extensively considered in this Note. Although these documents often have limited statutory authority to control the treatment decision, they may have evidentiary significance in court proceedings where the court seeks to determine the patient's preferences. *See, e.g., Conroy*, 98 N.J. at 361-63, 486 A.2d at 1229-31.

18. *In re* Storar, 52 N.Y.2d at 380, 420 N.E.2d 64 (mentally retarded 52-year-old patient); Superintendent of Belchertown State School v. Saikewicz, 373 Mass., 728, 749-51, 370 N.E.2d, 417, 427-29 (1977) (mentally retarded 67-year-old patient).

a formerly competent patient may have expressed no treatment preference at all, or she may have offered expressions of doubtful reliability or applicability to her present medical condition.[19] This Note focuses on the third class of incompetent patients.

A. The Right of Self Determination and Substitute Judgment

At common law, a competent person's right of self determination gives her essentially unrestricted authority to limit others' contact with her body.[20] The doctrine encompasses a patient's right to refuse medical treatment even when such refusal is life threatening.[21] It is especially strong against countervailing interests[22] when the refusal is by a dying patient and relates to medical treatment that cannot restore the patient's health.[23]

Since the right of self determination can only be exercised by a person competent to evaluate her condition, a patient lacking this capacity forfeits her right of self determination unless the surrogate decision-maker, standing in the place of the incompetent, asserts the patient's preference.[24] This surrogate decision-making is embodied in the doctrine of substitute judgment.[25] Courts will rely on the substitute judgment doctrine only when the surrogate decision-maker demonstrates the incompetent person's preferences with reasonable certainty.[26] When the

19. *See, e.g., Conroy*, 98 N.J. at 339-40, 486 A.2d 1209 (patient had expressed no preference, but feared doctors and had refused to see one when she contracted pneumonia); *Quinlan*, 70 N.J. at 41, 355 A.2d at 664 (patient had left several statements of little probative value).

20. In *In re* Conroy the court noted, "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law . . ., 'The right to one's person may be said to be a right of complete immunity: to be let alone.' " 98 N.J. at 346, 486 A.2d at 1221-22 (citing Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) (refusing to compel personal injury plaintiff to undergo pretrial medical examination)).

21. *Id.* at 353, 486 A.2d at 1225.

22. These interests include the state's interests in preserving life, preventing suicide, protecting innocent third parties, and maintaining the integrity of the medical profession. *Conroy*, 98 N.J. at 348-49, 486 A.2d at 1223.

23. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

24. *See* Note, *supra* note 16, at 1296-97.

25. For a useful summary of the substitute judgment rule, see Superintendent of Belchertown State School v. Saickewicz, 373 Mass. 728, 751-52, 370 N.E.2d 417, 431 (1977).

26. *See, e.g., In re* Conroy, 98 N.J. 321, 360-61, 486 A.2d 1209, 1229 (1985); *In re* Colyer, 99 Wash. 2d 114, 125, 660 P.2d 738, 745 (1983); Eichner v. Dillon, 52 N.Y. 2d 363, 377, 420 N.E. 2d 64, 71 (1981). *But cf. Saickewicz*, 373 Mass. 728, 752-53, 370 N.E. 2d 417, 431 (1977), where the court held that "the [treatment] decision in cases such as this [of a mentally retarded patient] should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person." The court opined that this decision-making formula is not inconsistent with the use of the substituted judgment doctrine:

patient expresses a treatment preference prior to her loss of competence, the court views the surrogate as merely supplying the capacity to enforce the incompetent's choice. Thus, a dying patient's right of self determination outweighs the rights of the patient's family, physician, or other care provider to base a treatment determination on their individual interests or ethical imperatives.[27] The irreversible incompetent's right of self determination also outweighs the state's interest in preserving life, preventing suicide, protecting third party dependents of the dying patient, and preserving the ethical integrity of the medical profession.[28]

The crucial trigger for the exercise of substitute judgment is a determination of what the incompetent's choice would be if she were competent. In the relatively few cases where the patient's preference is clear, substitute judgment is the proper surrogation method.[29] When a court cannot determine a patient's preference, strict application of the substi-

---

> Joseph Saickewicz [the patient] was profoundly retarded and noncommunicative his entire life. . . . While it may thus be necessary to rely to a greater degree on objective criteria, such as the supposed inability of profoundly retarded persons to conceptualize or fear death, the effort to bring the substituted judgment into step with the values and desires of the affected individual must not be abandoned.

Id. at 752-53, 370 N.E. 2d 430-31.

27. *Conroy*, 98 N.J. at 350-53, 486 A.2d at 1223-25;

28. *Id.*

29. Brophy v. New England Sinai Hospital, 398 Mass. 417, 427, 430-33, 497 N.E. 2d 626, 631, 633-35, (1986); *Saikewicz*, 373 Mass. at 752-59, 370 N.E.2d at 431-35; Eichner v. Dillon, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 72 (1981). The *Conroy* court also developed a subjective test for elderly, incompetent, severely impaired nursing home residents with a life expectancy of a year or less. Based on the substitute judgment rule, this test would allow the foregoing of life support "when it is clear that the particular patient would have refused the treatment under the circumstances involved," 98 N.J. at 360-64, 486 A.2d at 1229-31.

For two examples of the use of substitute judgment to assert the right of self determinaion for incompetent patients who have left a clearly expressed preference, see *Eichner*, 52 N.Y.2d 363, 420 N.E.2d 64 (1981), and *Brophy*, 398 Mass. 417, 497 N.E.2d 626 (1986). In *Eichner*, Brother Fox, an 83-year-old member of a Catholic religious order, suffered severe brain damage during surgery and fell into an irreversible "vegetative coma." *Id.* at 371, 420 N.E. 2d at 67. The court found that Father Eichner, Brother Fox's religious superior, demonstrated by clear and convincing evidence that Brother Fox had expressed a desire that treatment be withdrawn from him under such circumstances.

After quoting Justice Cardozo ("[every person] of adult years and sound mind has a right to determine what should be done with his own body," *Eichner*, 52 N.Y.2d at 376, 420 N.E.2d at 70 (quoting Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914))), the court found that neither the state's interest in protecting the lives of its citizens nor a doctor's obligation to provide medical care outweighs "the right of the competent adult to make his own decision [regarding a cessation of life support]." *Eichner*, 52 N.Y.2d at 377, 420 N.E.2d at 71. The court rejected the district attorney's arguments that any right the patient may have is entirely personal and not open to exercise by any third party, and that a substitute judgment would deprive the patient of his fourteenth amendment right to life. *Id.* at 377, 420 N.E. 2d at 71. Since Brother Fox had made the decision for himself before he became incompetent, *id.* at 379-80, 420 N.E.2d at 72, the court concluded that the surrogate would "give effect to [Brother Fox's] right by carrying out his stated intentions." *Id.* at 379-80, 420 N.E.2d at 72. The court stressed the importance of clear and convincing evidence matching

tute judgment doctrine becomes impossible. In such a case, allowing a surrogate to substitute her judgment for that of the patient would result in the surrogate's supplying the content of the incompetent's choice, rather than merely implementing that choice.[30] This clearly violates the principles underlying the use of substitute judgment to effectuate a patient's right of self determination.[31] Thus, courts do not normally rely on a surrogate to supply a treatment decision for a patient who has not previously expressed a clear preference on the issue.[32]

B. The "Best Interest" Test and *Parens Patriae*

When the dying incompetent has not previously expressed a clear and reliable preference regarding treatment, a court must determine whether withdrawal of life support systems serves the patient's "best interests."[33] The court derives its authority to render decisions from the

---

the surrogate's decision to the patient's serious and reliable expression of his preference. *Id.* at 379-80, 420 N.E. 2d at 72.

In *Brophy*, 398 Mass. 417, 497 N.E.2d 626 (1986), an irreversibly comatose patient had expressed to his wife on numerous occasions over several years a strong preference against receiving life support treatment if he should become irreversibly comatose. *Id.* at 427, 497 N.E.2d at 631. The probate court nonetheless refused to allow the patient's preference to control the treatment decision. Life support involved a plastic "G-tube", a simple, nonmechanical device that used gravity to pass food and water directly into the patient's stomach. *Id.* at 427, 497 N.E.2d at 630. The probate court found that the G-tube was not "painful, uncomfortable, burdensome, unusual, hazardous, invasive or intrusive, even in relation to a conscious patient," *id.* at 426, 497 N.E.2d at 631, and that patients had lived relatively comfortably for up to thirty-seven years on the G-tube. *Id.* at 437, 497 N.E.2d at 637. Because "death by dehydration is extremely painful and uncomfortable," it could not "be ruled out" that Brophy might experience a painful death if the G-tube were removed. *Id.* at 426 n.20, 497 N.E.2d at 631 n. 20. The probate court thus concluded that the patient's best interests required that life support continue despite the patient's preference. *Id.* at 422, 497 N.E.2d at 628-29 n.5.

Reversing this holding as "paternalistic," *id.* at 431, 497 N.E.2d at 633, the Massachussetts high court held that the patient's right of self determination should control. *Id.* at 430, 497 N.E.2d. at 633. Despite the relatively nonintrusive effect of the G-tube, the high court found that the other requirements to keep Mr. Brophy alive were intrusive as a matter of law, triggering his right to refuse treatment.

30. In *Saikewicz* the Massachussetts Supreme Judicial Court acknowledged that a mentally retarded patient "had no capacity to understand his present situation or his prognosis." 373 Mass. at 750, 370 N.E.2d at 430. The court nonetheless applied the substituted judgment rule. *Id.* at 751, 370 N.E.2d at 430-31. *See supra* note 26.

31. *Conroy*, 98 N.J. at 364-65, 486 A.2d at 1231.

32. The New Jersey Supreme Court applied a strained version of substitute judgment by allowing the patient's father to decide the treatment issue despite his inability to demonstrate how his daughter would have decided if she had been competent. *Quinlan* 70 N.J. at 41-42, 355 A.2d at 664. *See infra* notes 107-76 and accompanying text.

33. The key question for such court-controlled decisions is whether evidence of patient values goes only to show clear and reliable patient preference on the treatment question sufficient to trigger the patient's right of self determination and an exercise of substitute judgment, or whether such evidence, even though inconclusive, might influence the *court's* criteria in applying the best interest test. Under a *Conroy*-type best interest test, *see infra* notes 43-47, 52-

common law duty to protect the vulnerable and helpless. Under the doctrine of *parens patriae*,[34] the court must protect those who are incapable of exercising their own rights.

In addition to serving as the incompetent's advocate under the *parens patriae* doctrine, the court must also enforce state policies that favor prolonging life.[35] Neither statutory law nor common law defines the balance of these state interests relative to the rights of dying incompetents who have expressed no clear preference.[36] The courts must thus perform in two potentially conflicting roles. On the one hand the court must advocate the interests of the incompetent who did not express a treatment preference but who may nonetheless wish to discontinue treatment. On the other hand the court must support the state's frequently unclear policies to "protect" dying incompetents from a third party's decision to end life support. Under these circumstances, it is not surprising that courts experience difficulty in interpreting the law[37] and may be accused of judicial legislation.[38]

Whether the judge functions as interpreter of the law or as legislator, the lack of a patient's expressed preference necessitates *court-defined* criteria for making a treatment decision.[39] One approach considers the treatment question "objectively", focusing primarily or exclusively on the patient's medical condition and likelihood of experiencing physical

56 and accompanying text, evidence would preclude application of the patient's right of self determination, and the public policy favoring maintenance of life support would control. 98 N.J. at 967-68, 486 A.2d at 1233. This imposition of the state's preference could eliminate the possibility of ending life support, even if the termination of treatment were a reasonable alternative based on the patient's values. In short, this means that in protecting the unexpressed right of the dying incompetent, the court gives its own content to that right and refuses to defer to the patient, even when some reliable evidence indicates that the state view dishonors the patient it stands bound to protect. *Id.* at 385-86, 486 A.2d at 1242-43.

34. *See supra* note 10. "This [doctrine] permits the state to authorize guardians to [withdraw life support] from an incompetent patient if it is manifest that such action would further the patient's best interests in a narrow sense of the phrase, even though the subjective test . . . may not be satisfied." *In re* Conroy, 98 N.J. at 365, 486 A.2d at 1231.

35. *See, e.g., Conroy*, 98 N.J. at 345, 486 A.2d at 1233.

36. Regarding statutory law, the *Conroy* court acknowledged that "neither [of two New Jersey statutes concerning the rights of the institutionalized elderly] provides specific guidelines concerning termination of life-sustaining treatment." *Conroy*, 98 N.J at 345,486 A.2d at 1221. While policy seems difficult to discern on the part of the courts, the *Conroy* court noted, "Everyday, and with limited legal guidance, families and doctors are making decisions for patients like Claire Conroy." *Id.* Courts are thus required to develop policy guidelines in this area. *Id.*

37. *See supra*, notes 13, 17, and 36.

38. *See, e.g., In re* Guardianship of Grant, 109 Wash. 2d 545, 575, 747 P.2d 445, 460 (1987) (Andersen, J., concurring in part and dissenting in part) ("I am not convinced that the members of this court and the lawyers before it have a better ability to understand and decide the underlying issue of very basic public policy than have the electorate or their elected representatives in the Legislature. . . . I consider the Legislature to be the preferred body to deal with this issue and would defer to it.").

39. *See supra* notes 2, 36 and 32. *See also infra* notes 40-49 and accompanying text.

suffering.[40] Under the objective approach, the court will presume that the reasonable, competent patient suffering from certain medical conditions would choose to discontinue treatment.[41] A second approach involves the determination of the patient's probable subjective desires.[42]

The New Jersey Supreme Court in *In re Conroy*[43] suggested two types of objective best interest tests. First, the court described a "limited-objective test" that would allow termination of life support when there is "some trustworthy evidence that the patient would have refused treatment, *and* the decision-maker is satisfied that *it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him.*"[44] Second, the court proposed a "pure-objective test" to be applied when there is no trustworthy evidence of a patient's preference.[45] As in the limited objective test, the surrogate decision-maker seeking to end life support must first demonstrate that the burdens on the patient as a result of treatment "markedly outweigh" the benefits of life with the treatment.[46] A court would authorize termination of life sustaining treatment under the pure objective test only if a second test is also met: "recurring, unavoidable and severe pain of the patient's life with the treatment [is] such that the effect of administering life sustaining treatment would be inhumane."[47]

In contrast to the objective tests proposed by the court in *Conroy*, the report of the President's Commission for the Study of Ethical

40. *See, e.g., Conroy*, 98 N.J. at 366-67, 486 A.2d at 1232 ("limited-objective" and "pure-objective" best interest tests focusing primarily on balancing the benefits and burdens of living with treatment under specific medical circumstances).

41. *See infra* notes 43-47 and accompanying text.

42. Two courts have adopted best interest tests emphasizing a patient's values as well as her medical condition. *See Saikewicz*, 373 Mass. at 752, 370 N.E.2d at 431; Barber v. Superior Court, 147 Cal. App. 3d 1021, 195 Cal. Rptr. 493 (1983). Because of the subjective quality of these tests, however, "best interests tests" is a misnomer. They are better described as "patient values" tests, or "loose" substitute judgments. *See infra* text at p. 18 and note 103 and accompanying text.

43. 98 N.J. 321, 486 A.2d 1209 (1985).

44. 98 N.J. at 967-68, 486 A.2d at 1232 (emphasis added). The court defines the "burdens" to be considered strictly in terms of physical suffering, while the "benefits" may include "any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life." *Id.* at 365, 486 A.2d at 1232. Because the dying incompetent patient's cognitive abilities are frequently either ended or severely impaired, both "benefits" and "burdens" of these "objective tests" refer, in effect to physical conditions, as observed by one dissenter: "While the basic standard [in the objective tests] purports to account for several concerns, it ultimately focuses on pain as the critical factor. The presence of significant pain in effect becomes the sole measure of such a person's [like Ms. Conroy] best interests. 'Pain' thus eclipses a whole cluster of other human values that have a proper place in the subtle weighing that will ultimately determine how life should end." *Id.* at 394, 486 A.2d at 1247 (Handler, J., concurring in part and dissenting in part).

45. *Id.* at 967-68, 486 A.2d at 1232.

46. *Id.* at 366, 486 A.2d at 1232.

47. *Id.* at 967-68, 486 A.2d at 1232.

Problems in Medicine and Biomedical and Behaviorial Research[48] advocated a best interest test that focuses on the patient's likely subjective wishes. Under this broad best interest test, a surrogate would draw upon his and others' intimate familiarity with the patient to determine the patient's likely values and desires in relation to the treatment decision. These values would be related to the patient's medical condition and level of pain.[49] This subjective test avoids the danger of automatically imposing on the dying incompetent a presumption that her best interests should be defined according to a public policy favoring prolongation of life support.

C. The Limits of the Common Law

The common law doctrines of self determination and *parens patriae* inadequately protect the privacy interest of patients who have expressed no clear preference regarding treatment. The policy underlying the right of self determination does not distinguish competent from incompetent patients;[50] the right can be asserted, however, only by a currently competent patient or by an incompetent patient who expressed a clear preference while competent.[51] Since a patient with "no expressed preference" fits neither of these categories, he cannot avail himself of the protections available under the doctrine of self determination.

The *parens patriae* doctrine is equally unavailing in this context. Both the limited and the pure-objective best interest tests suggested by the New Jersey Supreme Court in *Conroy* define the patient's best interests according to judicially established criteria as distinct from the patient's values. Under *Conroy*, a "no expressed preference" patient who actually prefers to discontinue artificial life support but whose continued existence does not involve "recurring, unavoidable and severe pain," will be kept alive against her will.[52] Under the first prong of the *Conroy* limited-objective test, which looks for "some trustworthy evidence that the patient would have refused treatment,"[53] the court may consider the patient's values as "some trustworthy evidence" of the patient's preference to end life support. Applying the second prong, however, the court would emasculate the influence of any such consideration; while the *patient's* implied measure of the burdens and benefits of life support, as indicated by the "trustworthy evidence," would argue *against* continued

48. PRESIDENT'S COMM'N, *supra* note3, at 135.

49. *Id.* at 136. For a judicial application of this test, see Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 424 (1983), discussed *infra* at text accompanying notes 143-161.

50. *Conroy*, 98 N.J. at 360, 486 A.2d at 1229.

51. *See Eichner*, 52 N.Y. 2d at 379-80, 420 N.E. at 72 (clear and convincing evidence of patient's preferences needed to forego life support in patient's name).

52. 98 N.J. at 366, 486 A.2d at 1232. *See supra* notes 43-44 and accompanying text.

53. *Conroy*, 98 N.J. at 967-68, 486 A.2d at 1232.

treatment, the court's focus on a physical benefits/burdens calculus would control the decision. The patient's values thus do not affect the weighing of the benefits and burdens; they merely preclude the court from imposing the pure-objective test's additional criterion that the patient must be suffering "recurrent, unavoidable and severe pain." The patient's values make possible a decision based on a test which is relatively easier to meet than the pure-objective test, but still completely court defined according to objective criteria, and still quite severe.[54]

For example, suppose a vegetative patient kept alive by a simple feeding tube[55] had left only "some trustworthy evidence" that he considered the humiliation of helplessness and constant handling to be a compelling reason not to continue treatment, even assuming his life could be maintained with little or no discomfort. Under the *Conroy* limited-objective test, the court would be unable to order termination of life support since neither the feeding tube nor physical handling produces physical pain sufficient to "markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life."[56] In such a case application of the *parens patriae* doctrine through the best interest test would contradict the goal of the policy behind the right of self determination. An opportunity to enable a patient to influence his own treatment decision would be disregarded in favor of the court's perception of the "objective" preconditions needed to end life support. By assuming against the evidence that the patient prefers to prolong his life, the court entirely ignores the patient's own values.

Among the various common law tests available to courts considering treatment alternatives, only the subjective best interest test assures some patient influence over the treatment decision. But because the subjective test injects a patient's preference into the judicial determination, the test actually falls outside the scope of the *parens patriae* doctrine. Under its obligation as *parens patriae*, the court normally undertakes an active role as guardian of those individuals who suffer from some legal disability. In the case of a dying patient, the court stands in the place of the incompetent to protect his rights. In contrast, the court's essential duty under the "subjective" best interest test proposed by the President's

54. *See supra* note 44.

55. This type of tube was the life support at issue in *Brophy*, 398 Mass. 417, 497 N.E. 2d 626. *See supra* note 29.

56. 98 N.J. at 967-68, 486 A.2d. at 1232. Under the circumstances suggested in this example the *Conroy* test may very likely encourage perjury. A loved one may be unable to produce sufficient evidence to establish a clear preference by the patient, although years of intimate sensitivity to the patient's attitudes, conduct and beliefs make the patient's decision clear in the mind of the loved one. Fearful of the results of the *Conroy* best interest test, an intimate might fabricate the evidence necessary to keep the decision under his control. Given the privacy of such communications generally, and the absence of contrary evidence of the patient's intent, the court would be hard pressed to discover the perjury without some obvious misstatement by the witness.

Commission is to surrender representation of the patient's interests to a surrogate. Using this test, the judge does not apply her own best interest test, but defers to the surrogate, who formulates and applies the test based on the patient's values, virtually without judicial supervision.[57] To describe this form of judicial abstention as an exercise of its role as protector of the incompetent strains the *parens patriae* doctrine. Judicial inaction in the case of the dying incompetent is tantamount to judicial deference to the patient's privacy right. Use of the subjective best interest test indicates judicial recognition that both traditional tools of the common law—the right of self determination and the judiciary's *parens patriae* duty to stand in the incompetent's place to protect her interests—cannot enable the court to decide responsibly for the patient who has expressed no clear preference.

II. The Right to Privacy and Dying Incompetents

Since both common law doctrines of self determination and *parens patriae* fail to protect the rights of patients who have expressed no treatment preference, the courts should adopt a privacy right rationale consistent with the twin goals of the common law—to assure maxumum patient influence on the treatment decision and to protect the patient from a decision against her best interest. A sound privacy right analysis must first address the evidentiary dilemma of assessing a patient's preference when the patient has not clearly indicated her wishes; second, it must ensure maximum patient influence over the surrogate decision; and third, it must clarify the court's role in promoting a surrogate decision-making process that most closely resembles the patient's own decision-making process and is most likely to produce a result in accord with the patient's wishes.

A. The Constitutional Right to Privacy

In 1965 the United States Supreme Court first described the constitutional right to privacy in *Griswold v. Connecticut.*[58] In *Griswold*, the Court found that a Connecticut statute prohibiting the use of contraceptives impermissibly violated the privacy of the marriage relationship.[59] Acknowledging that the Constitution contained no explicit reference to a right of privacy, the Court nonetheless reasoned that a "penumbra" of privacy rights emanating from certain amendments to the Bill of Rights[60]

57. *See infra* notes 143-161 and accompanying text.

58. 381 U.S. 479 (1965)(plurality opinion).

59. *Id.* at 485-86. Justice Douglas reviewed Supreme Court cases in which the court held that the Constitution protects the following rights: the right to educate a child in a school of the parents' choice, the right to study a particular subject or foreign language, the rights to distribute, receive and read literature, rights of association, expression and belief, and rights of "privacy and repose." *Id.* at 482-85.

60. *Id.* at 484.

creates a "zone of privacy" within which certain intimate choices are immune from governmental interference.[61] According to the Court, without this "zone of privacy," the constitutionally explicit protections of these amendments would be undermined.[62]Because the Court deemed "fundamental" the right of a married couple to make procreative decisions, it would allow state action in this area only when the government could demonstrate a compelling interest.[63] The statute at issue in *Griswold* did not meet this burden.

The Court's use of this "penumbra" theory evoked sharp criticism. Justice Black, in dissent, rejected the idea of giving constitutional stature to a "right of privacy," in part because of the vagueness of the term. He warned that reliance on the privacy right as a "comprehensive substitute for the Fourth Amendment's guarantee against 'unreasonable searches and seizures' " would distort the scope of explicit constitutional rights: " '[P]rivacy' is a broad, abstract and ambiguous concept which can easily be shrunken in meaning but which can also . . . easily be interpreted as a constitutional ban against many things other than searches and seizures."[64] Justice Stewart also declined to accept the "penumbra" theory stating that he could find "no such general right of privacy in the Bill of Rights, in any other part of the Constitution, or in any case ever before decided by this Court."[65] Numerous commentators have also criticized the Court's analysis.[66] Although these criticisms suggest flaws in the definition and scope of the privacy right and in the logic linking the privacy right to explicit constitutional protections, the status of the right as "fundamental" is now firmly entrenched in our constitutional law.[67]

---

61. *Id.* In reaching its decision, the Court relied on the First, Third, Fourth, Fifth and Ninth Amendments. A plurality of the Court found that certain "zones of privacy" created by the "emanations from those [Bill of Rights] guarantees . . . help give [these Amendments] life and substance." Id. at 484.

62. *Id.* at 481-82.

63. *Id.* at 509.

64. *Id.* at 530.

65. *See, e.g.,* Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410, 1424-27 (1974) (The Court has not clarified the "touchstone for determining 'fundamentality' " nor "why Privacy satisfies that test" in the case of some but not other areas of individual choice); GRISEZ & BOYLE, *supra* note 4, at 55 (Under the Supreme Court's rationale "[n]o one can say what the right of privacy might embrace, except in the conclusion of an argument showing what liberties ought to be respected more than others or in the conclusion of an argument showing what the Supreme Court is likely to decide"); *see also* Posner, *The Uncertain Protection of Privacy in the Supreme Court*, 1979 SUP. CT. REV. 173, 199 (1979) for a criticism of the Supreme Court's expansion of the privacy right in Eisenstadt v. Baird, 405 U.S. 438 (1972), and Roe v. Wade, 410 U.S. 113 (1973)(what is private is "simply what the Court thinks should not be subject to public control").

66. *See, e.g.,* Roe v. Wade, 410 U.S. 113, 152 (1973). *See also* NOWAK, ROTUNDA AND YOUNG, *supra* note 16, at 684-85.

67. Eisenstadt v. Baird, 405 U.S. 438 (1972).

Although the *Griswold* Court did not clearly define "privacy", the Court since *Griswold* has expanded the concept to protect unmarried individuals' procreative rights[68] and a woman's right to terminate a pregnancy under certain circumstances.[69] The Supreme Court has not yet considered a case in which a surrogate seeks to invoke a dying incompetent's privacy right to withdraw life support treatment.[70] However, several state high courts have relied on the patient's privacy right in such cases,[71] beginning with the New Jersey Supreme Court's landmark *In re Quinlan* decision.

B. *Quinlan*'s Use of the Privacy Right

In 1976, twenty-two-year-old Karen Ann Quinlan fell into a coma after suffering brain damage of unknown origin.[72] Her doctors described her condition as a "persistent vegetative state."[73] Karen's father petitioned the trial court to appoint him as Karen's guardian and specifically requested authority to disconnect a respirator that the doctors believed necessary for her survival.[74] The court denied Mr. Quinlan's petition after finding that statements made earlier by Karen did not indicate relia-

68. Roe v. Wade, 410 U.S. 113 (1973).

> "[This] Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. . . . Only personal rights that can be deemed 'fundamental' or 'implicit' in the concept of ordered liberty, . . . are included in this guarantee of personal privacy. . . . [The privacy] right has some extension to activities relating to marriage, . . . procreation, . . . contraception, . . . family relationships, . . . and child rearing and education."

Id. at 152-53 (citations omitted).

69. In his concurrence in Roe v. Wade, Justice Douglas, author of the plurality opinion in *Griswold*, suggested that the zone of privacy encompasses the "freedom to care for one's health and person [and] freedom from bodily restraint or compulsion." *Id.* at 213 (Douglas, J., concurring).

70. *See supra* note 7.

71. 70 N.J. at 23, 355 A.2d at 654.

72. At the hearing, a medical expert described a subject in this state as one "who remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function." *Id.* The "vegetative" functions control body temperature, breathing, chewing, swallowing, sleeping and waking, and, to some degree, blood pressure and heart rate. They are distinguished from the "sapient" function, which controls one's relations with the outside world and skills such as the cognitive tasks of talking and thinking. *Id.* at 24, 355 A.2d at 654.

73. *Id.* at 25, 355 A.2d at 655.

74. The trial court had refused to admit into evidence Karen's prior statements which indicated

> distaste for continuance of life by extraordinary medical procedures, under circumstances not unlike those of the present case. These quoted statements were made in the context of several conversations with regard to others terminally ill and being subjected to like heroic measures. The statements were advanced as evidence of what she would want done in such a contingency as now exists . . . [i.e.,] not to have her life prolonged by the otherwise futile use of extraordinary means. . . . [W]e agree with the conception of the trial court that such statements, since they were remote and impersonal, lacked significant probative weight.

bly what Karen's preference might be on the treatment question.[75]

The New Jersey Supreme Court reversed the trial court and granted Mr. Quinlan's petition.[76] The court explained:

> If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to [consultation with attending physicians and a hospital ethics committee] as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them. It is for this reason that we determine that Karen's right of privacy may be asserted in her behalf, in this respect, by her guardian and family under the particular circumstances presented by this record.[77]

Thus, the court held that *Karen's* privacy right provided the legal basis for her *father* to assert Karen's *presumed* desire to discontinue her life support treatment. The court effectively authorized Karen's surrogate, her father, to participate in *constructing*, not merely *implementing*, his daughter's decision to withdraw life support.

Despite the novelty of its decision, the court failed to define the privacy right or explain its relationship to the right of self determination. In relying on a privacy right analysis, the court extended the boundaries of Karen's control over the treatment decision beyond her common law right to reject intrusive bodily contact.[78] The court determined that Karen's right to privacy persisted despite her incompetency and outweighed both the state's interest in preserving life and her father's interest in acting as a parent for his daughter's benefit. In effect, the privacy right protected Karen from imposed decision-making "for" her in such a way that no action could be taken at all without some judicially-fashioned relief. Since the court found that inaction would equally violate

---

Id. at 21-22, 355 A.2d at 653. The Supreme Court later asserted: "[W]e cannot discern [Karen's] supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight." *Id.* at 41, 355 A.2d at 664.

75. *Id.* at 41, 355 A.2d at 664.

76. *Id.* at 41-42, 355 A.2d at 664. The opinion has been widely criticized for its "legislative" thrust and dubious reasoning. *See, e.g.* P. RAMSEY, ETHICS AT THE EDGES OF LIFE, 268-99 (1979); GRISEZ & BOYLE, *supra* note 4, at 283-87.

77. GRISEZ & BOYLE, *supra*, note 4, at 98 (the *Quinlan* court should have based its decision on the "familiar and long-standing common law right of bodily integrity").

78. A "true" substitute judgment would occur only if the surrogate merely implemented a choice earlier asserted by Karen. *See supra* notes 42a-75 and accompanying text.

her privacy right, it allowed a kind of quasi-substitute judgment[79] by permitting Karen's father to exercise her right to control the course of treatment. Thus, Mr. Quinlan acted not from his position as a parent but as Karen's intimate, one the court could trust to implement Karen's own decision. This was apparently the best the court believed it could do to honor Karen's privacy.[80] The solution clearly violated the strict substitute judgment rule because Karen had left no expression of her preference on the treatment question.[81]

Two conclusions can be drawn from the court's view of the privacy right: first, the privacy right can in some circumstances limit the court's *parens patriae* control over the treatment decision; and second, the right to privacy and the right of self determination, although related, do not offer identical protection. Although the *Quinlan* does not explore this aspect of its holding, one's right to privacy under *Quinlan* provides significant additional protection not available under the right of self determination.

1. The Right to Privacy and Parens Patriae

The New Jersey Supreme Court initially cited United States Supreme Court cases[82] as prohibiting "judicial intrusion into many aspects of personal decision,"[83] and stated that the right to privacy "[p]resumably [would] encompass a patient's decision to decline medical treatment under certain circumstances."[84] This language suggests that the court believed the treatment decision was sufficiently private that it should not involve itself with the considerations by which Karen, if competent, might arrive at a decision to terminate treatment. The court did not consider Karen's incompetence a reason to require court involvement in the construction of a treatment decision in Karen's name. Karen's father failed to demonstrate that Karen had previously expressed an opinion on treatment alternatives in these circumstances; nonetheless, the court allowed Mr. Quinlan to decide whether or not to withdraw artificial life support. The court did not indicate a need to protect Karen from the possibility that her father might make a decision contrary to Karen's actual desires.

---

79. Indeed, the court held that Karen's right of privacy outweighed any rights Mr. Quinlan possessed as a father, 70 N.J. at 22, 355 A.2d at 653.

80. *See supra* note 74.

81. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663.

82. The court cited Eisenstadt v. Baird, 405 U.S. 438 (1972); Stanley v. Georgia, 394 U.S. 557 (1969); Griswold v. Connecticut, 381 U.S. 479 (1965); Roe v. Wade, 410 U.S. 113 (1973). The court also cited the privacy right provision of the New Jersey Constitution, Art. I, par. 1. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663.

83. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663.

84. The court noted, "[N]o physician risked the opinion that she could live more than a year and indeed she may die much earlier." 70 N.J. at 26, 355 A.2d at 655.

Apparently, the court believed the right to privacy established a zone of privacy within which a patient with "no expressed preference" could control her health care decisions. Honoring this zone of privacy required the court to protect Karen from its own assertion of an imputed preference under the *parens patriae* rule. The court elected to leave the difficult task of balancing Karen's values and interests in the more reliable hands of her father.

Another consideration supports the court's belief that its obligation under the *parens patriae* doctrine was of limited value in resolving the treatment dilemma. The area of privacy at issue in *Quinlan* was specific and uniquely personal: a dying individual's decision to maintain or terminate arguably useless medical care.[85] The common law right of self determination implicitly assures a competent patient a zone of privacy in this context, suggesting that the decision-making *process* is itself beyond the purview of the court. Because the patient's considerations in arriving at a treatment decision are inherently personal, submitting such considerations to the depersonalizing process of public adjudication destroys the privacy to which these patients are entitled.

Were she competent to evaluate her circumstances, Karen would likely weigh together her fears, memories, struggles, and challenges, ultimately arriving at a resolution to the treatment problem. This intensely personal process, based on Karen's exploration of values and perceptions personal to her, would be protected from judicial intervention by the right of self determination.[86] Although the common law thus acknowledges and protects the relevance of these personal features of the decision-making process, their subtle interrelations and inherently personal nature would be lost if subjected to a public adjudicatory process. Similarly, judicial involvement directed toward imputing a preference to Karen based on strictly objective criteria would preclude any influence Karen might otherwise have on the decision-making process.

Karen's decision could never be certain, of course, as long as she remained incompetent. Someone she loved and trusted, however, who relied on Karen's values, would stand a better chance of arriving at a decision that more closely resembled Karen's own than that of the court. In sum, *Quinlan* suggests that when a court is satisfied that a trustwor-

---

85. *See infra* text at pp. 36-39 (interests/values distinction).

86. The New Jersey high court accepted the trustworthiness of Mr. Quinlan as an intimate of Karen's:

> The trial court was apparently convinced of the high character of Joseph Quinlan and his general suitability as guardian under other circumstances, describing him as 'very sincere, moral, ethical and religious.' . . . [W]e sense from the whole record before us that while Mr. Quinlan feels a natural grief, and understandably sorrows because of the tragedy which has befallen his daughter, his strength of purpose and character far outweighs these sentiments and qualifies him eminently for guardianship of the person as well as the property of his daughter.

Id. at 53, 355 A.2d at 670-71.

thy[87] intimate of the incompetent is available to utilize the patient's values in constructing a treatment decision, the patient's privacy right requires that the court avoid affirmatively exercising its *parens patriae* duty and withdraw from the decision-making process.

2. *The Right to Privacy and Self Determination*

Quinlan states that the right to privacy "encompass[es] a patient's decision to decline medical treatment under certain circumstances . . . ."[88] Although this language suggests that the boundaries of the right to privacy and the right of self determination are coterminous, in fact the right to privacy recognized in *Quinlan* is broader than the right of self determination in two respects. First, the right of self determination assumes that the patient alone is competent to exercise the right either while competent or through having clearly expressed a preference while competent.[89] Second, a surrogate decision-maker properly exercises substitute judgment to enforce the patient's right of self determination only when she knows the patient's actual preference.[90]

As previously discussed, the right of self determination assumes that the cognitive abilities of the *self* are intact at the time the *determination* is made.[91] If an incompetent patient has not previously expressed a competent opinion on the treatment issue, the right of self determination fails to control the facts at hand and the court assumes its *parens patriae* duty. In this scenario, the court resorts to a "best interest" test to protect the patient.[92] In *Quinlan*, the court invoked the privacy right to enable Karen to influence the treatment decision through her father's intimacy with her values and perceptions. Karen's influence on the decision thus survived her incompetency despite the fact that she had not clearly expressed her thoughts on the subject while competent.[93] In this respect, Karen's privacy right offered her more protection from judicial involvement in the decision-making process than would her common law right of self determination.

In discussing United States Supreme Court decisions affirming the right to privacy, the *Quinlan* court also cited cases in which the privacy right was related to certain interpersonal as well as personal choices, in-

87. *Id.* at 40, 355 A.2d at 663.

88. *Conroy*, 98 N.J. at 364, 486 A.2d at 1231. *See also supra* notes 20-32.

89. *Conroy*, 98 N.J. at 364, 468 A.2d at 1231

90. *See supra* notes 20-32, 49-51 and accompanying text.

91. *See supra* notes 33-47 and accompanying text.

92. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

93. In introducing the privacy right into its analysis, the court discussed Supreme Court decisions relating to the use of contraceptives by married and single persons as well as a woman's right to terminate a pregnancy. *Id.* at 40, 355 A.2d at 663 (citing *Griswold v. Connecticut*, 381 U.S. 479 (1965); Eisenstadt v. Baird, 405 U.S. 438 (1972); Roe v. Wade, 410 U.S. 113 (1973)).

cluding intimate marital and family-related decisions.[94] Citing *Roe v. Wade*, the court observed: "[T]his right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions.[95] The court alluded to the right of self determination but did not rely on it to provide Karen with the level of protection she needed, turning instead to her right to privacy. Moreover, in implying that Karen's right to privacy outweighed her need for possible protection from her father, the court enlarged the applicability of the substitute judgment rule, implicitly acknowledging a substantial identity of interests between Karen and her father on the limited point of determining the course of treatment.[96]

C. Policy Implications of *Quinlan*

In *Quinlan*, the court was more concerned with crafting an equitable remedy in the face of particular, tragic facts than with fashioning policy based on recognized holdings and facts that could be readily generalized.[97] Yet despite its loose reasoning, the decision has far reaching implications. The court's invocation of Karen's privacy right profoundly affected the roles of the judiciary, patient, and surrogate in cases of dying incompetents.

The court effectively limited its role to deferring to the trustworthy surrogate's judgment regarding the patient's wishes on the treatment question. The surrogate assumed the responsibility, however, of acting in conformity with the patient's values rather than according to the surrogate's perception of the patient's best interests. If the court had believed

---

94. *Quinlan*, 70 N.J. at 39-40, 355 A.2d at 663 (citing Roe v. Wade, 410 U.S. at 153).

95. The court stated:

> We have no doubt . . . that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death.

Id. at 41, 355 A.2d at 663. The court then explored the constitutional right to privacy, noted Karen's "extremely poor" prognosis, and concluded that Karen's choice, if she were competent to make it, would be vindicated by the law. The court then stated:

> Our affirmation of Karen's independent right of choice . . . would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, when such testimony is without sufficient probative weight. . . . Nevertheless we have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.

Id. at 41, 355 A.2d at 664 (citations ommitted).

96. *Id.* at 41-42, 355 A.2d at 664.

97. *Id.* at 22, 355 A.2d at 653. The court did address policy questions surrounding physicians' potential liability in determining the medical conditions which justify withdrawing treatment. *Id.* at 48-50, 355 A.2d at 668-69. Such medical policy questions are separate from the constitutional question of the patient's right to control her medical treatment.

that the surrogate would not decide according to the patient's values, it would not have considered the surrogate trustworthy.[98]

Only a privacy right analysis can effectively clarify the crucial distinction between values and interests in the predicament of the patient who has expressed no clear preference. While the two concepts are closely related, values, unlike interests, are inherently personal. Values reveal a person's distinctively individual features. When the law permits them to control conduct, as in the right of self determination, values define individual privacy by determining the extent and weight of an interest in the context of other interests and particular circumstances. In establishing priorities among possible courses of conduct, an individual relies on her values to abandon or subordinate one interest in order not to injure another, more important interest. As features of one's individuality, values are inherently matters of fact, not law. Interests, however, as features of legal relationships, are defined by law.[99]

For example, in *Brophy v. New England Sinai Hospital*,[100] John Brophy's statement that survival by reliance on artificial life support "is not living"[101] expressed both a value and an interest. The right of self determination establishes as a matter of law a patient's *interest* in rejecting unwanted physical contact. Brophy's statement is significant because it clarifies his personal value judgment that this interest outweighs another legally established interest—that of preserving his life. In comparison, a neighboring, alert cancer patient, for example, might disdain the discomforts of chemotherapy. Like Brophy, she has an interest in rejecting treatment. Under her values and different medical circumstances, however, she might choose to subordinate that interest to her interest in prolonging her life.

A surrogate deciding for an incompetent, dying patient faces the dilemma of having to balance two squarely opposed interests of the patient: his interest in remaining alive and his interest in freeing himself of arguably useless medical intervention. Which interest is "best" for the patient should be determined by the patient's *values*. A privacy right analysis suggests that the surrogate's role is to weigh these and any other relevant, competing interests according to the patient's wishes, while the court's role is to facilitate the decision-making process without pre-empting the patient's values with "objective" legal interests. Even when applying a subjective "best interests" test, courts should abandon the

98. *See supra* note 86. The New Jersey Supreme Court specifically rejected the trial court's view "that the obligation to concur in the medical care and treatment of his daughter . . . would distort [Mr. Quinlan's] 'decision-making processes.' " *Id.* at 53, 355 A.2d at 671.

99. "Interest" is "[t]he most general term that can be employed to denote a right, claim, title, or legal share in something. . . . More particularly it means a right to have the advantage accruing from anything . . . ." BLACK'S LAW DICTIONARY (5th ed. 1979) 729.

100. 398 Mass. 417, 497 N.E. 2d 626 (1986). *See supra* note 29.

101. *Brophy*, 398 Mass. at 417, 497 N.E.2d at 632 n.22.

paternalistic "best interest" terminology in favor of a "patient values test," which explicitly acknowleges the patient's right to privacy.

The *Quinlan* court's suggestion that the judiciary should recognize the incompetent patient's privacy right augments the protections available under the right of self determination and improves upon the best interest test. While the right of self determination effectively ends with the absence of a patient's clearly expressed preference, the privacy right protects the patient who has not expressed a preference. Through the surrogate, the patient's values acquire the vitality to control the treatment decision. The privacy right also provides protection unavailable under the "objective" best interest test[102] by de-emphasizing the evidentiary dilemma presented by the patient with "no expressed preference."[103] By invoking Karen's right to privacy,[104] *Quinlan* gave priority to the constitutional surrogation method that most closely assures access to the patient's values and preserves at least some patient influence on the treatment decision.[105]

Nine years later, the New Jersey Supreme Court retreated from this bold decision, de-emphasizing the privacy right and stressing the right of self determination and *parens patriae* doctrines. In *In re Conroy*[106] the court held that it had earlier erred in *Quinlan* by excluding weak evi-

102. *See, e.g.*, Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). *See infra* notes 143-157 and accompanying text.

103. If courts redefined the "best interest" test to equate a patient's "interests" with her values, ascertained by a trustworthy surrogate, an accommodation of patient values would occur. However, the term "best interest test" would then be a misnomer. *See supra* text accompanying note 137.

104. See *Conroy*, 98 N.J. at 365-66, 486 A.2d at 1232, for a discussion of the types of evidence useful in the view of the New Jersey Supreme Court in determining whether an incompetent patient has left a clearly expressed preference on the treatment question. *See infra* note 112 and accompanying text.

105. The policy behind the right of self determination accords a patient control over the decision to reject *or receive* treatment. *In re* Conroy, 98 N.J. at 360, 486 A.2d at 1229 ("[B]oth aspects of the patient's right to bodily integrity—the right to consent to medical intervention and the right to refuse it—should be respected."). By highlighting the *patient's values*, tendencies to divert the decision-making criteria from what the patient would want to what a court, physician, or relative considers "best" should be largely averted. *See infra* note 162.

106. The *Quinlan* decision has been criticized for not suggesting how its use of the right to privacy would equally safeguard a patient's right to remain alive when treatment is not useless. *See* GRISEZ & BOYLE, *supra* note 4 at 285. ("Since the rights to receive as well as to refuse treatment are not given equal attention, the court's decision creates a danger that the equal protection of the law of homicide will be denied to the noncompetent, who will be killed by malevolent denial of due care.").

It has also been argued that an incompetent patient's right to privacy is infringed when a guardian is allowed to make personal medical decisions on the patient's behalf. Smith, *In re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L. J. 150, 161 (1976). This view, however, fails to account for the fact that *neglecting* to terminate treatment when such a step is medically indicated and in accord with the patient's values would more seriously infringe the patient's right to privacy, since the silence of incompetence cannot denote consent to treatment.

dence regarding Karen's views on the treatment question.[107] This position was consistent with *Conroy*'s overall approach of rigidly enforcing "best interest" criteria when a patient's preference was unclear while expanding relevancy standards to admit as much evidence as possible regarding a patient's preference.[108]

"Though couched in constitutional terms of the right to privacy," the *Conroy* court asserted, "the underlying concept [in *Quinlan*] was an individual's right to behave . . . as he deems fit, provided that such behavior . . . [does] not conflict with the precepts of society."[109] The court then asserted that *Quinlan* required a "showing sufficient to demonstrate [Karen's wishes]."[110] It offered five factors to guide the lower courts in their evaluation of the probative value of wide ranging evidence: (1) remoteness of the statements or actions, (2) their consistency, (3) thoughtfulness, (4) specificity, and (5) the maturity of the person at the time of the statements or acts.[111]

Under this test, Karen Quinlan's conversations, of little probative value in the view of the trial court,[112] would fail all but the "consistency" test. An application of the *Conroy* rationale to the *Quinlan* facts would thus have required the court to deny Mr. Quinlan's petition.

The *Conroy* court also asserted that *Quinlan* authorized the guardian to "express [Karen's] intent . . . provided that the decision that *she* would have made was also objectively reasonable."[113] It is unclear whether the *Conroy* court believed *Quinlan* intended to place limits on the decision *Karen* might have made. Clearly the *Quinlan* emphasis on Karen's privacy right suggests otherwise. *Conroy* noted that *Quinlan* incorporated an objective constraint on the guardian's assessment of Karen's subjective considerations when it stated that a decision to withhold life support "should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them."[114] In effect, *Conroy* suggested—clearly consistently with *Quinlan*—that Karen's incompetency terminated a portion of her rights to privacy and self determination: her right to choose an alternative treatment was objectively viewed as unreasonable.

Thus the *Conroy* court, in its treatment of *Quinlan* and its emphasis on "objective" best interests tests for patients with "no expressed prefer-

107. 98 N.J. 321, 486 A.2d 1209 (1985).

108. 98 N.J. at 362, 486 A.2d at 1230.

109. *Id.* at 362, 364-65, 486 A.2d at 1230-31.

110. *Id.* at 358, 486 A.2d at 1228.

111. *Id.*

112. 98 N.J. at 362, 486 A.2d at 1230.

113. *See supra* note 74.

114. 98 N.J. at 358, 486 A.2d at 1228 (emphasis added).

ence,"[115] re-opened the following questions to which the *Quinlan* court had already provided enlightened answers:

> 1. If the court's *parens patriae* duty runs to the patient, and the interest of the patient in asserting her own values can best be protected by deferring to the judgment of a trusted intimate of the patient, should the court employ its own best interest test? Can the court alone effectively weigh the patient's privately defined "best interest"?
> 2. Should the court defer to a state's interest in controlling such treatment decisions despite an outcome likely to be different from the patient's preference, as indicated by trustworthy intimates of the patient?
> 3. Does a patient effectively forfeit her privacy right by virtue of her failure to leave a clear expression of her intent on the withdrawal of treatment question?

III. Application of the Privacy Right Rationale

Two recent cases highlight the courts' struggles to define their role in surrogate decision-making for patients who have expressed no clear preference regarding treatment. Judicial adoption of a privacy right theory would clarify the nature and scope of the court's duty in this context.

A. *In re Guardianship of Grant*[116]

Barbara Grant was a twenty-two-year old victim of Batten's disease, a degenerative and incurable neurological disorder.[117] Judith Grant, her mother and legal guardian, petitioned the court for authority to discontinue Barbara's life support systems.[118] At the time of the hearing, Barbara's intellectual and cognitive functions had virtually disappeared.[119] Although Barbara had not "explicitly expressed her desires regarding the use of life sustaining medical treatment,"[120] her mother "believe[d] [Barbara] would not want such treatment.[121] Barbara's immediate family and her guardian *ad litem*, appointed in addition to her mother, concurred.[122] Only a separate "attorney for Barbara Grant," specially appointed by the trial court, opposed the motion to forego life support.[123] The trial court heard testimony offered by Barbara's mother and priest. Based on Barbara's behavior and general value statements concerning her death and religious beliefs, this testimony indicated that Barbara, if

115. *Id.* at 358, 486 A.2d at 1228 (quoting *Quinlan*, 70 N.J. at 42, 355 A.2d at 647).
116. *See supra* notes 43-47 and accompanying text.
117. 109 Wash. 2d 545, 747 P.2d 445 (1987).
118. *Id.* at 547, 747 P.2d at 446.
119. *Id.*, 747 P.2d at 446.
120. *Id.* at 549, 747 P.2d at 447.
121. *Id.* at 550, 747 P.2d at 448.
122. *Id.*, 747 P.2d at 448.
123. *Id.* at 551, 747 P.2d at 448.

competent, would have chosen to forego life support.[124] The trial court nonetheless denied the petition, concluding that Barbara's mother had no power to decide the treatment question. Acting in violation of Barbara's likely preference, the court held that it would authorize withdrawal of treatment only if it could make a "substituted judgment" that Barbara, if competent, would choose to refuse life support.[125]

The Washington Supreme Court reversed,[126] stating that the trial court's choice was itself a "decision by default."[127] Reasoning that "the incompetent's right to refuse treatment should be equal to a competent's right to do so,"[128] the high court observed that this right "stems from both the constitutional right of privacy and the common law right to be free of bodily invasion."[129] As in *Quinlan*, the court in *Grant* declared the relevance of the privacy right without explaining how the patient's privacy interest related to the choice of treatment alternatives.[130] The court's analysis also failed to provide a rationale linking the patient's right to refuse treatment under the common law doctrine of self determination to the patient's constitutional right to privacy. The court held that prior court authorization would not necessarily be required and that "these [treatment] decisions are best left, wherever possible, to the incompetent patient's guardian, immediate family and physicians."[131] The court concluded, "[T]he guardian's familiarity with the incompetent patient's character and personality, general attitude towards medical treatment, and prior statements would assist [the guardian] in making this judgment."[132] Significantly, the court did not explicitly require a guardian to comply with even a patient's clearly expressed preference, although the patient's wishes "must be given strong consideration, even if [expressed] while the patient was incompetent."[133]

---

124. *Id.* at 565, 747 P.2d at 456.

125. *Id.* at 550, 747 P.2d at 448.

126. *Id.* at 547, 747 P.2d at 446. Four justices concurred with Justice Callow in his majority opinion. Justices Andersen and Brachtenbach concurred in part; Justice Goodloe, joined by Justice Dore, dissented.

127. *Id.* at 558, 747 P.2d at 452.

128. *Id.* at 552, 747 P.2d at 449 (citing *In re* Colyer, 99 Wash. 2d 114, 124, 660 P.2d 738 (1983)).

129. *Id.* at 553, 747 P.2d at 449.

130. Again quoting *Colyer*, the court stated: "The decision by the incurably ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a 'fundamental' decision in their lives, that it is virtually inconceivable that the right of privacy would *not* apply to it." *Id.* at 553, 747 P.2d 449 (quoting *Colyer*, 99 Wash. 2d at 120, 660 P.2d 738) (emphasis in original).

131. *Id.* at 566, 747 P.2d at 456.

132. *Id.* at 567, 747 P.2d at 457.

133. *Id.*, 747 P.2d at 457. The court's precise meaning on this point is not clear. The court places heavy emphasis on the privacy right, and indicates, immediately after this "strong consideration" language, that a patient-centered best interests determination is necessary "where it cannot be ascertained what choice the patient would make if competent." *Id.*, 747 P.2d at 457. This language suggests that "strong consideration" should be read to signify "controlling

Under *Grant*, when the surrogate cannot ascertain the patient's choice, she must decide according to the patient's best interests.[134] The court proposed a "nonexclusive list" of factors for the surrogate to consider: the patient's physical, sensory, emotional, and cognitive functioning, her pain and other medical circumstances, and the "degree of humiliation, dependence and loss of dignity probably resulting from the condition and treatment."[135]

One dissenter attacked the majority's view as being "in direct conflict with this court's duty to preserve life."[136] He argued that Washington State's Natural Death Act indicated the legislature's intent that life support may be ended only in those cases where competent adults make this decision for themselves; he felt that the right to life was too personal to be exercised by a surrogate.[137]

Although purporting to advance the privacy interests of patients like Barbara Grant, the Washington Supreme Court's analysis was severely flawed. The court undermined its assertion that a patient's desires properly control the treatment decision with its vigorous insistence that the patient's family be protected from the consequences of a patient's survival, and its statement that a patient's surrogate decision-maker should give "strong"—but by implication not necessarily controlling—weight to the patient's clearly expressed preference.[138]

Moreover, the court did not require the guardian to evaluate the factors for and against life support from the *perspective* of the patient. Without distinguishing the patient's values from her interests,[139] the court's best interest test permits the surrogate to base his judgment on either his own or the patient's values. Since the surrogate can inject his own personal values, the dissent is correct in observing that the court's

---

consideration". However, the court also states: "The prolongation of the existence of this vegetative state for possibly years to come by artificially placing liquids and nutrients into this body to the emotional and economic destruction of the survivors is a monstrous assault to the family concerned that we will not countenance." *Id.* at 565, P.2d at 455. The latter strongly worded view clearly suggests that the patient's possible preference to *continue* treatment, even if deserving protection under the privacy right, should *not* receive controlling consideration in the surrogate's decision-making. Thus the court's "strong consideration" language may be an adroit word choice making the privacy right operable in one direction only—enabling the patient's choice to *end* life support to control the surrogate's decision, while freeing the surrogate to diregard the patient's views and privacy right should the patient prefer to impose on his family the "monstrous assault" of surviving. Of course, a court decision permitting the latter "one-way" use of the privacy right would appear to violate the Equal Protection Clause. U.S. Const. Amend. XIV.

134. *Id.*, 747 P.2d at 457.

135. *Id.* at 568, 747 P.2d at 457 (quoting *Conroy*, 98 N.J. at 397, 486 A.2d 1209 (Handler, J., concurring in part and dissenting in part)).

136. *Id.* at 575, 747 P.2d at 460 (Goodloe, J., dissenting).

137. *Id.*, 747 P.2d at 461 (Goodloe, J., dissenting).

138. *See supra* note 133.

139. *See supra* text pp. [36-39].

decision-making formula would allow a guardian effectively to disregard the patient's privacy right and implicitly to measure the value of the patient's remaining life as "negligible."[140]

In addition, the majority apparently interpreted its duty to protect the incompetent as requiring physicians to discontinue Barbara's life support.[141] The court thus implicitly based its *own* duty to protect the patient on the *guardian's* determination of the patient's bests interests. Here the court obviously confuses the roles of surrogate and court. In presenting an overbroad and inadequately explained interpretation of its own duty under the *parens patriae* doctrine and of the patient's rights of self determination and privacy, the majority allowed the court's responsibility as *parens patriae* to disappear in an excessive deference to surrogate decision-makers.

Finally, the dissent's criticism proceeds from a premise that is insensitive to the patient's right to privacy. In the dissent's view, Barbara's right to life imposed on the court a duty to presume she would want to continue treatment. This view of the court's obligation, like that of the trial court, suggests that a public policy in favor of life controls the treatment issue even where the patient's own wishes, though not explicitly in favor of ending life support, strongly suggest such a preference. To the dissent, inadequate evidence regarding the patient's preference automatically triggers a public rather than a private determination, a conclusion dictated by law rather than a patient-influenced question of fact.

In re Guardianship of Grant makes clear that conflicting interpretations of the rights of self determination and privacy and the *parens patriae* duty lead to divergent and irreconcilable results. These doctrines can be integrated to serve the paramount concern of the law in this area—that of promoting patient influence over the treatment decision[142]—only through a privacy right rationale.

To apply a privacy right rationale to the facts in *Grant*, the court would first need to determine whether Mrs. Grant were trustworthy and reliable to act as Barbara's surrogate. If she were approved, the court would then instruct her to familiarize herself thoroughly with the nature of Barbara's illness, degree of functioning, and earlier expressions of perspectives and values that might be relevant to her present circumstances. Third, the court would advise Mrs. Grant that her daughter enjoys a constitutional right to control the treatment decision and that Mrs.

140. *Grant*, 109 Wash. 2d at 579, 747 P.2d at 463 (Goodloe, J., dissenting).

141. Having determined that the patient had the right to have life-sustaining treatment withheld, *id.* at 556, 747 P.2d at 451, the majority observed that "the trial court's resolution of this matter [by denying the petition to end life support] would effectively deny Barbara Grant the right to withhold life sustaining procedures altogether." *Id.* at 558, 747 P.2d at 452.

142. *See, e.g., Conroy*, 98 N.J. 321, 360, 486 A.2d 1209, 1229 ("[T]he goal of decision-making for incompetent patients should be to determine and effectuate, insofar as possible, the decision that the patient would have made if competent.").

Grant's or other third persons' values and interests must not enter into that decision. Fourth, the court would obtain the guardian's oath that she would construct a decision for Barbara according to Barbara's values, consistent with the court's procedural instructions. If necessary, the court would adjudicate any disputes between other third parties and the guardian concerning Mrs. Grant's qualifications or performance of her duties. Finally, the court would declare the guardian immune from civil or criminal liability for her compliance with these procedures provided she acts in good faith.

B. *Barber v. Superior Court*

In *Barber v. Superior Court*,[143] the California Court of Appeals dismissed murder charges against two physicians who had withdrawn life support from Clarence Herbert, a brain-damaged incompetent facing "an indefinite vegetative existence."[144] The doctors had acted in response to a request by the patient's wife and other family members.[145]The court found that the doctors were not under an affirmative duty artificially to prolong Mr. Herbert's life[146] and held that "the patient's own desires and feelings,"[147] as expressed before the onset of incompetency, should guide the treatment decision. If the Court could not ascertain the patient's preference, it would apply the best interest test described in the President's Commission Report:[148]

> Under this standard, such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life may be considered. Finally, since most people are concerned about the well being of their loved ones, the surrogate may take into account the impact of the decision on those people closest to the patient.[149]

The court observed that "[t]here was evidence" that Mr. Herbert had expressed a desire to discontinue life support systems in the event of irreversible incompetency[150] and concluded that his wife "was the proper person to act as a surrogate for the patient with the authority to decide issues regarding further treatment."[151] The court observed:

> [Herbert's] wife and children were the most obviously appropriate surrogates in this case. They were the people who would be most affected by the decision and were in the best position to know Mr. Herbert's own feelings and desire. In addition, there was clear evi-

143. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).
144. *Id.* at 1013, 195 Cal. Rptr. at 487-88. *See supra* note 72
145. *Id.* at 1010, 195 Cal. Rptr. at 486.
146. *Id.* at 1022, 195 Cal. Rptr. at 493-94.
147. *Id.* at 1021, 195 Cal. Rptr. at 493.
148. PRESIDENT'S COMM'N, *supra* note 3, at 134-35.
149. 147 Cal. App. 3d at 1021, 195 Cal. Rptr. at 493.
150. *Id.* The court did not, however, discuss standards of evidence.
151. *Id.*

> dence that they were concerned for his comfort and welfare and some or all of them were present at the hospital nearly around the clock.[152]

The court also found no evidence that the family members were "motivated in their decision by anything other than love and concern for the dignity of their husband and father."[153]

The test described in *Barber* stands in sharp contrast to the best interest tests proposed by *Conroy*.[154] *Barber* clearly discourages judicial surrogation by assigning authority to a trustworthy surrogate intimate with the patient. The court's language in formulating its test includes subtle, qualitative elements that avoid precisely limiting the list of factors the surrogate could consider. The surrogate's effective control over the decision and the absence of a clear and convincing standard of evidence of the patient's expressions makes judicial authority over the process virtually impossible. Moreover, *Barber* does not require the surrogate to apply for judicial approval prior to the termination of treatment,[155] further vitiating judicial control over the decision-making process.

Since the court found "some evidence" of Mr. Herbert's preference, it is not certain that the court would advocate minimal judicial involvement when evidence of the patient's preference were weak or nonexistent.[156] Its language, however, suggests a clear intention to use the test to assist the surrogate in making a decision consistent with the choice the patient would have made.[157]

Barber suggests that a court must first determine the trustworthiness

---

152. *Id.* at 1021 n.2, 195 Cal. Rptr. at 493 n. 2.

153. *Id.* at 1021, 195 Cal. Rptr. at 493.

154. *See supra* notes 43-47 and accompanying text.

155. *Id.* at 1021, 195 Cal. Rptr. at 493.

156. It is also not immediately clear from the *Barber* opinion whether *additional* or *stronger* evidence of the patient's preference would increase or decrease the need for judicial involvement. If *Barber* represents a policy of giving preference to an intimate surrogate's judgment over that of a judge, additional evidence would increase the likelihood that the trustworthy surrogate would make an appropriate choice, thereby decreasing the need for judicial supervision. If, however, *Barber* represents a policy preferring judicial oversight of an intimate surrogate's judgment where evidence is strong, more reliable indications of patient preference would trigger *greater* judicial supervision to ensure that these indications of the patient's likely preference are not disregarded as the surrogate constructs a decision.

Two features of the *Barber* decision suggest that the first of these policy views best characterizes the court's position. First, the *Barber* court simply did not address the question of evidence standards, suggesting a basic confidence in the surrogate's ability and willingness to weigh evidence responsibly. Second, the court did not find that a surrogate's right to decide the treatment question without judicial approval hinged on any particularly high or low threshold of reliable evidence, suggesting again that the court believed the patient's interests would be protected even without judicial supervision. 147 Cal. App. 3d at 1021, 195 Cal. Rptr. at 493.

157. This interpretation is also supported by the court's desire to appoint a surrogate who was "in the best position to know Mr. Herbert's own feelings and desire." *Id. See also supra* text accompanying note 151.

of the proposed surrogate.[158] If the court found the surrogate trustworthy, it could expect her to apply the best interest test without need for judicial oversight. As a practical matter, the *Barber* test appears to presume that the surrogate is reliable. The "best interest test" proposed by *Barber* thus represents judicial circumlocution for deference to the judgment of the patient's private representative. While this may honor the patient's privacy right when this representative/surrogate is trustworthy and reliable, the *Barber* opinion provides little guidance to the surrogate in key areas. The court should instruct the surrogate to clarify that the patient's privacy right requires that the surrogate fulfill specific responsibilities.[159] For example, the surrogate should be thorough in collecting information regarding the patient's condition, prognosis and expressions of value judgments, including those which may have been expressed to others besides the surrogate. The court's *parens patriae* duty should obligate the court to provide such legal direction to the surrogate to protect the proper exercise of the patient's privacy right. With the court's duties fulfilled, the *Barber* test would lead to a similar result as occurred in *Quinlan*: a private surrogate decision-maker, intimate with the patient, unguided by the patient's explicit preference but familiar with the patient's values, obtains judicial authorization to resolve the treatment question.[160]

C. A Privacy Right Rationale

Summarizing the analysis above, this Note suggests the following privacy right rationale as a model for deciding whether life support should be withheld from dying incompetents who have loved ones at hand capable of serving as surrogate decision-makers and who have not expressed a clear preference on this subject.

A. The right to privacy should apply where patients who have expressed no clear preference have surrogate decision-makers at hand who are intimate with the patient's values.

1. The decision concerning life support is fundamental and personal to the dying patient.

2. The common law right of self determination allows dying patients to decide to continue or end treatment. The pa-

158. This duty would arise from the court's obligation under the *parens patriae* doctrine to act to protect the interests of the helpless patient. *See supra* notes 10, 33-34 and accompanying text. The *Barber* opinion presents a relatively cursory treatment of the court's duties relative to the surrogation process. *Id.* at 1021-22, 195 Cal. Rptr. at 493. It should be noted that the issue before the court in *Barber* did not directly implicate the court's *parens patriae* duty to protect the interests of a helpless patient. The court was called upon to decide the propriety of murder charges brought against the patient's physicians. *Id.* at 1010, 195 Cal. Rptr. at 486.

159. *See Quinlan*, 70 N.J. at 41-42, 355 A.2d at 664.

160. 70 N.J. 10, 355 A.2d 647; *see infra* notes 71-106 and accompanying text.

tient is normally unaccountable to the state or to third parties for her decision.

3. When a patient succumbs to irreversible incompetency without having earlier expressed a preference on the life support question, she cannot directly control the decision, and a decision must be made for her.

4. The patient's right to decide implies the patient's right to control or at least influence the decision made by a surrogate.

5. Where the dying incompetent's intimate values are known to a surrogate, the surrogate may infer the patient's decision by applying the patient's values to all the medical and nonmedical facts relevant to the patient's decision.

6. The common law right of self determination presumes that the *patient* competently formulates decisions concerning her physical status; thus, it does not reach patients whose preferences must be determined indirectly.

7. Therefore, the right to privacy, exercised by a responsible surrogate, should be available to the dying incompetent to further the goal of the patient's autonomy where irreversible incompetence and the lack of a clearly expressed preference make the right of self determination inapplicable.

B. The court can protect the patient's right to privacy and fulfill its *parens patriae* duty by limiting its involvement in the surrogation process to determining the reliability of the surrogate and properly instructing the surrogate to promote the fullest possible exercise of the patient's privacy right.

1. The court has a duty under the *parens patriae* doctrine to protect the rights of the helpless patient.

2. In this context, the court can best protect the patient's interests by promoting the exercise of the patient's privacy right, which orders the priority of a patient's interests according to the patient's values.

3. The court can best promote the exercise of the patient's privacy right by requiring a decision-making process most likely to produce the result the patient herself would reach.

4. To fulfill the court's duty under B (1), (2) and (3), the court must authorize the surrogation *process* that most closely resembles the patient's own decision-making process.

5. A patient's decision-making process would rely heavily on uniquely personal perceptions, experiences and values. The interrelations of these individual elements in a decision-making process, if presented to a court, would at best present a

series of nonjusticiable, conclusory assertions of priorities among legal interests, producing a nonjusticiable result. Hence there can be no meaningful judicial oversight of the patient's decision-making *process*, only of its procedures and results.

6. A surrogate sensitive to the patient and properly instructed to consider the patient's perceptions and values as the sole criteria in resolving the treatment dilemma may construct a decision inferentially as indicated in A (5). Such decision-making by a reliable private surrogate will more likely arrive at the decision the patient would have made than will a decision-making process in which the court applies "objective" criteria or seeks to perform itself the process described in B (5).

7. Because of the nonjusticiable character of the process described in B (5), and because "objective" criteria fail to consider properly the patient's values, judicial surrogation in this context would constitute unconstitutional state interference with the patient's privacy right, unless the patient has no qualified intimate to serve as surrogate. Only in the latter case is judicial surrogate decision-making proper, on the basis that there is no other party capable of asserting the patient's rights, and the court's *parens patriae* duty therefore requires affirmative judicial involvement. Wherever possible, however, the court should avoid entering the private world of the patient's confrontation with death and her decision regarding arguably useless treatment.

8. When the court has determined that a responsible surrogate exists, it should facilitate the private surrogation process described in B (6) in order to advance properly the interests of the incompetent patient as secured through the exercise of the patient's right to privacy. The court should limit its role to the following:

a. determining the reliability and trustworthiness of the surrogate;

b. advising the surrogate of his role, including the specific duty to employ as criteria in reaching a treatment decision *only* the values of the patient;

c. prescribing for the surrogate specific tasks generally supportive of the surrogation process. These tasks would include medical consultation and any other information-gathering necessary to enable the surrogate to become fully informed of the specific circumstances facing the patient and of the patient's probable preferences under such circumstances;

d. securing the surrogate's oath to comply with the court's instructions;

e. adjudicating disputes concerning either the surrogate's trustworthiness or actual performance of his duties;

f. protecting surrogate decision makers from criminal or civil liability when the surrogate has acted properly under these procedures.

Conclusion

In *Quinlan*, the New Jersey Supreme Court invoked the right to privacy to provide a helpful remedy for dying incompetents who leave no clear expression regarding preference on the treatment question but who are supported by trustworthy intimates. *Quinlan* validates a patient centered, values based surrogation where both the right of self determination and a court formulated "objective" best interests test cannot assure patient influence on the treatment decision.[161] Expanding on *Quinlan*, a

161. Some commentators object to private decision-making as creating a "right to kill," since private persons might determine that another's life should end. NOWAK, ROTUNDA & YOUNG, *supra* note 16, at 720-21. This objection first relies on a controversial notion: that a homicidal act occurs where arguably useless medical treatment is ended. Courts generally have rejected this view of termination of treatment decisions on the theory that the disease, not the withdrawal of treatment, is the cause of death, and the patient would not be committing suicide by exercising her right to end treatment. *See, e.g., Conroy*, 98 N.J. at 350-51, 486 A.2d at 1224 ("Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury."). *See also In re* Colyer, 99 Wash. 2d 114, 123, 660 P.2d 738, 743 (1983) ("A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient.").

A more serious defect in this "right to kill" argument, however, is that it proves too much. Best interest tests such as those set forth in *Conroy*, 98 N.J. at 364-67, 486 A.2d at 1231-32, do not absolutely prohibit withdrawal of life support. Foregoing life support by court order under either of these tests, according to the "right to kill" view would constitute a form of state sanctioned "execution," similar to the alleged private party's "right to kill," since the only differences between the private and public decision-maker—the identity of the decision-maker and the standards controlling the decision—are irrelevant to the decision's effect on the patient's right to life. The state would thus need to demonstrate a compelling interest sufficient to warrant such a homicidal act against a vulnerable and innocent person. Since this clearly would be impossible, absent an impermissible evaluation of the worth of the patient's life, there could be no constitutionally valid best interest test, only an absolute prohibition against withdrawing artificial life support under any circumstances where the patient has not expressed a preference to end treatment. Thus the noncommunicative or undecided patient—even in cases of terrible suffering where the *Conroy* pure-objective test would allow ending life support—would be required to continue life indefinitely, however severe her pain or protracted her misery, and regardless of the clear fact that no recovery could be expected.

The value of the "right to kill" objection lies in its appropriate moral warnings in two areas. First, the patient's so-called "right to die" does not abridge the laws against suicide or euthanasia, hence it does not imply a "right to kill" on the part of the surrogate. *See* GRISEZ & BOYLE, *supra* note 4, at 290-91. To permit a surrogate to terminate treatment because the *surrogate* believes ending treatment is in the patient's best interest would circumvent the patient's right to privacy. Thus, in determining the trustworthiness and capability of an intimate who petitions for surrogation rights, the court should find by clear and convincing evidence

model privacy right theory would require the court to certify a proposed surrogate as capable and trustworthy and to protect the patient's interests by imposing limited procedural safeguards on the surrogate.[162] These safeguards would ensure that the surrogate has evaluated the patient's condition in the same manner as the patient herself might do. The court should also require the surrogate to explore fully indications of the patient's preference.

This approach would properly reassert the importance of the right to privacy as espoused by *Quinlan* and would advance meaningfully humane public policy on behalf of persons rendered incompetent because of age or illness. Where an individual has lost the opportunity to assert personal control over her last moments, the law should permit her to have the "right" person act in her place. Courts should endorse such surrogate decision-making as an expression of the patient's constitutional right to privacy. This approach also conforms to the common law goal of promoting a patient's autonomy and is preferable to benignly motivated but ultimately disrespectful and intrusive judicial control over a dying patient's last decision.

*By Gary Underwood Scharff**

---

that the petitioner has clearly distinguished his own values from those of the patient and has sworn to decide the treatment question only according to the patient's values. While the boundary between patient and surrogate values is clearly difficult to patrol, the court's examination of the petitioner and of evidence challenging the petitioner's suitability should normally enable the court to determine whether the patient's privacy right will be respected.

A second moral lesson of the "right to kill" opponents relates to the delicate questions of policy which these treatment dilemmas raise and the inherently fact-sensitive challenges which cannot be resolved by rules of law. The impact of medical technology on the process of dying compels realization of a uniquely urgent social responsibility: as a society we tread this ground—the intensely private world of the death of another human being—not because we have an inherent right to be there, but because we must take responsibility for a technical power that could harm the vulnerable and helpless even more ruthlessly if we were to stay away.

162. In *Quinlan* the New Jersey Supreme Court required Mr. Quinlan to consult with Karen's attending physicians and a hospital ethics committee. 70 N.J. at 54, 355 A.2d at 671. *Conroy* also discussed the procedural requirements imposed by statute in the event of possible abuse of an elderly, institutionalized person. 98 N.J. at 378-88, 486 A.2d at 1239-44.

* A.B., Princeton University (1974); M.A., Graduate Theological Union (1983); Member, third year class.