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The Quinlan Case

Dennis J. Horan

This is an expanded version of a paper presented to the Medicine and Law Committee of the American Bar Association, Atlanta, Ga. in August, 1976.

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Although its importance cannot be overestimated, the decision of the New Jersey Supreme Court in the matter of Karen Quinlan¹ bears little or no resemblance to the newspaper accounts of the case. Its importance is related more to the impact of the media than the logic of the opinion. In its opinion of March 31, 1976 the New Jersey Supreme Court really addressed two rather diverse topics: (1) the Karen Quinlan case, and (2) the right of privacy in terminal illness. Whether it was necessary to discuss the latter in order to decide the former is questionable, and is a question which will be debated in the law reviews.

The judgment in the case is very narrow and is in sharp con-

trast to the wide breadth of issues discussed in the opinion. The judgment is contained in the last three pages of the opinion entitled "Declaratory Relief." In those pages the Court declared that upon the concurrence of the guardian and family of Karen the life support apparatus being administered to her (a Bennett Respiator) could be discontinued, but on certain conditions. These conditions were: (1) the concurrence of the responsible attending physicians who must conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state; and (2) the concurrence and agreement by a hospital ethics committee that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state.

Thereafter, withdrawal of the life support systems under those conditions shall be without any civil or criminal liability on the part of any participant, whether guardian, physician, hospital or others.

The Court then remanded the case to the trial court for implementation of certain narrow decisions: (1) to discharge the present guardian, and (2) to appoint

the father, Joseph Quinlan, as guardian with full power to make decisions with regard to the identity of Karen's treating physicians.

The narrowness of the actual Declaratory Relief is to be contrasted with the breadth of the body of the opinion which addresses itself to a whole series of issues, the discussion of which was not essential or even necessary for the determination of the case. I contend that the same decision as was reached by the Court could have also been reached by the Court merely by applying current medical-legal law, without the necessity of introducing such issues as the right of privacy or substitute judgment. The mischief these concepts will create remains to be seen.² In view of the post-decretal history of the case, and in view of Karen's survival for a lengthy period of time after removal from the respirator, my conclusions seem even more apt.³

The court brushed aside Mr. Quinlan's contention that his First Amendment rights of religious beliefs were impinged upon. Nor did the Court recognize an independent parental right of religious freedom to support the relief requested. Similarly the Court disposed of the Quinlan's argument based upon cruel and unusual punishment.

The Court did find in the constitutional right of privacy a right to reject medical treatment. Because of Karen's incompetency and her inability to exercise that right, the Court concluded that

Karen's right of privacy may be asserted on her behalf by her guardian "under the peculiar circumstances here present."⁴ The court thus chose to decide the case on constitutional grounds rather than attempting a resolution of the issues on current legal-medical principles. My thesis is that the case could have been decided and the same result reached without resorting to constitutional rights, and in particular the right of privacy.

Resorting to constitutional grounds means that the Court's holding cannot be changed or altered by the legislature. A constitutional amendment would be required. This can be a most difficult state of affairs in the resolution of legal-moral-medical problems, since it forecloses further social experimentation through legislation of other solutions to the legal dilemmas which resuscitation poses. Alternative solutions to profound legal problems such as these should not be foreclosed by the premature use of constitutional grounds. For the same reasons, resort should first be had by the Court to legal-medical precedents rather than constitutional principles. The law is only now beginning to cope with these profound medical-legal problems, and haste in decision-making which may produce constitutional solutions which are, practically speaking, henceforth unalterable, should be avoided.

The right to refuse medical treatment does not need constitutional support. A physician

may not render treatment without consent except in emergency situations. The fact that consent is necessary has never been considered to need statutory or constitutional support. The right to reject medical treatment exists as a corollary to the necessity for consent to any touching. A competent person has the right to refuse medical treatment, not as a constitutional right of privacy, but as a corollary of the common law tort rule that no one may treat him or her without that consent. This aspect of the right of privacy (refusal of medical treatment) is not constitutional in scope under the federal constitution. It obviously exists now as a constitutional right in New Jersey as a result of the opinion in the Quinlan case.

In an attempt to limit the breadth of many of the comments made, the Court concluded several paragraphs of the opinion with the statement, "under the peculiar circumstances here present."⁵ Why this should be repeatedly stated by the Court is unclear. Perhaps there was fear of the real nature of the issues which the Court knew the public thought was being decided.

The Court stated that 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 (i.e., she has a constitutional right to reject medical treatment), then it should not be

discarded solely on the basis that her condition prevents her conscious exercise of that choice. Speaking in practicalities, the Court felt that the only way to prevent destruction of this right was to permit the guardian and family of Karen to render their best judgment as to whether she would exercise it in these circumstances. The Court then found that Karen's right of privacy to terminate medical treatment could be asserted in her behalf by her guardian and family "under the peculiar circumstances presented by this record."⁶

Except in emergency situations where it is presumed, consent is a condition precedent for the giving of medical treatment. For minors and incompetents, consent must be sought from the parent or guardian. The consent may be given by them where the treatment is beneficial, but not otherwise. For termination of therapy the rules are similar, but not the same. All treatment requires consent, but the termination of therapy for medical reasons does not, as long as the patient is not being abandoned by the physician. As applied to the situation at hand, these principles mean that resuscitation therapy may be terminated where the prognosis for life (not meaningful life) is very poor and in the medical judgment of the attending physician continuation of the therapy is unwarranted. Consequently, the New Jersey Supreme Court need not have discussed the case as one requiring the application of constitu-

tional principles. Indeed, in doing so it has seemingly placed another burden on the shoulders of the physician. Presumably he now cannot terminate resuscitative therapy without the consent of the parent or guardian.

The Court next discusses what it labels "the medical factor." Under this heading is placed the most far-reaching and unsettling aspect of the case. Accepting the statement by the physicians in the case that their decision not to terminate the use of the respirator as a form of medical treatment was made according to prevailing medical practice and standards, the Court nonetheless determined that *it* should re-evaluate the applicability of the medical standards themselves.⁷ The Court specifically indicated that the decision of the physicians in charge of the case was consistent with the proofs below as to the "then"⁸ existing medical standards and practices. It even indicated that Judge Muir was correct in declining to authorize withdrawal of the respirator as the law then stood. Then, the Court addressed this, the most profound issue of the case, in a classic of unintelligible legal jargon:

"The question is whether there is such internal consistency and rationality in the application of such standards as should warrant their constituting an ineluctable bar to the effectuation of substantive relief for plaintiff at the hands of the Court. We have concluded not."⁹

In my opinion, this section of the Quinlan case will have the most profound effect on medical

practice in future years. For here the Court held that it could overrule the medical and moral standards prevailing in the profession of medicine. Judge Muir had held to the contrary, i.e., that the medical standards must be determined by the medical profession and could not be overruled by the Court.¹⁰ But the New Jersey Supreme Court took particular pains to address this issue in a manner which indicates that it, the New Jersey Supreme Court, would determine what the moral, medical and legal standard is as applicable to the termination of resuscitative methods. Lest there be any doubt about that conclusion, the Court reiterates:

"In summary of the present point of this opinion, we conclude that the state of the pertinent standards and practices which guided the attending physicians in this matter is not such as would justify this Court in deeming itself bound or controlled thereby in responding to the case for declaratory relief established by the parties on the record before us."¹¹

It would be much simpler if the Court had said that the attending physicians were wrong in their understanding of the prevailing standard. But the Court says they were right.^{11A} We must remember that courts have not heretofore dictated to physicians as to how they will conduct the practice of their profession. Even a judicial finding of malpractice usually requires the testimony of another physician that the applicable standard of medical practice has been breached. Where expert testimony is not

necessary, it is because the standard is self-evident or proved without oral testimony. Here, however, a state supreme court has decreed that a medical standard which, on the record below, was apparently accepted by all as the prevailing standard, can be discarded and replaced by another seemingly contrary standard. Yet, even that pronouncement seems to be at odds with the holding in the judgment that the attending physicians cannot turn off the respirator until both they and a hospital committee have decided that the treatment is hopeless. Such inconsistencies do not persuade a careful reader of the efficacy of the opinion. Under malpractice laws, what courts say is the prevailing medical standard becomes normative for the physician and mandates his future course of conduct.

The Court also holds that terminating the respirator in this case would not be criminal homicide because death would be from existing natural causes. However, even if it were to be regarded as homicide, the Court says it would not be unlawful because "a death resulting from such an act would not come within the scope of the homicide statutes proscribing only the unlawful killing of another."¹² The Court brings the person who turns off the respirator under the protection of the constitution by declaring that the one who exercises the constitutional right of privacy for another under these circumstances cannot be the subject matter of prosecution if the

other individual himself would not be subject to prosecution for refusing medical treatment.

Then, in a most extraordinary statement, the Court states: "and under the circumstances of this case these same principles would apply to and negate a valid prosecution for attempted suicide were there still such a crime in this state."¹³ Such a crime, "aiding suicide," is a crime under the proposed New Jersey Penal Code. The Court points out that even if the new criminal code becomes law, "this provision, if enacted, would not be incriminatory in circumstances similar to those presented in this case."¹⁴ I have not before seen a court render a declaratory judgment on a statute not yet in existence.

The case must be considered in the light of the facts as presented to the trial court and to the Supreme Court of New Jersey. At that time it was assumed by all participants that turning off the respirator meant almost immediate death for Karen Quinlan. Consequently, the case was argued in the trial court and on appeal as though the act of terminating a form of medical treatment constituted voluntary or involuntary euthanasia. The subsequent history of the case, and the fact that Karen Quinlan continues to survive without the aid of the respirator, has put the case in its proper perspective. That perspective is this: the Karen Quinlan case concerned a medical decision as to whether or not a certain type of medical therapy

should be continued in the case. That judgment should first of all be a medical judgment made by the physicians on the case. If the family concurs with that judgment, well and good. If, however, the family opts for a different form of medical treatment than the physicians on the case, the only practical answer is for the physicians to resign or to fire the physicians and replace them with other physicians. This, however, can be most difficult, as anyone who has been involved in such a case knows. Few physicians will involve themselves in taking over a case under those circumstances. This is seemingly what has occurred since the Court's opinion of March 31, 1976. The disagreement between the attending physicians and the family precipitated this litigation. In their judgment the attending physicians felt the case was not medically hopeless, and they refused to terminate the use of the respirator. Since the opinion, the same treating physicians have successfully weaned Karen from the respirator and she has been transferred to a nursing home. Given these basic disagreements between physician and family, who prevails?

Ordinarily one would expect the physician to resign in the face of such disagreement. How can he resign, however, without arranging for follow-up care (or be accused of abandonment), and what other physician wants to step into such a situation? The Supreme Court of New Jersey

solved this dilemma by giving the guardian (the father) the right to select the physician, even to the extent of firing the current physicians.

But on the important issue — the disagreement — it still held that the successor physicians must first agree that the case is hopeless before therapy can be discontinued. The Court then added another layer to the problem by requiring a hospital committee to do the same. This is the most puzzling aspect of the case. Presumably, the Court assumed that other physicians would be found after publication of the opinion who would take the case and would agree with the Court's opinion that the mere existence of a non-cognitive state or non-sapient state (whatever the Court means) is adequate grounds to stop the therapy.

Under current medical-legal principles, the Court had only to examine the facts and declare that a physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless. He is not mandated by the law to render useless treatment, nor does the standard of medical care require useless treatment. Under those circumstances if the treating physicians have determined that continued use of the respirator was useless, then they could decide to discontinue it without fear of civil or criminal liability. Thereafter reappointing the parent as guardian with the obvious

power to discharge the physicians if they disagreed with the family, was the only required solution. Whether the family can then find physicians who agree with them and will take the case is a separate issue.

By "useless" is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery. Even if the therapy is necessary to maintain stability, such therapy should not be mandatory where the ultimate prognosis is hopeless. This does not mean that ordinary means of life supports, such as food and drink, can be discontinued merely because the ultimate prognosis is hopeless. It does mean, however, that physicians can use good, practical, common medical sense in determining whether or not treatment is efficacious and, if it is not, then cease the treatment.

By "hopeless" is meant that the prognosis for life (not meaningful life) is very poor. The fact that someone may not return to "sapient or cognitive life" may or may not fulfill the requirement, depending on other medical factors, but in and of itself it does not. As was said by the Supreme Court of West Germany:

"Where human life exists, human dignity is present to it; it is not decisive that the bearer of this dignity himself be conscious of it and knows personally how to preserve it."¹⁵

It seems that in the Quinlan case all participants assumed that just as night follows day, death would follow the termination of

the respirator. Subsequent facts have proved this to be incorrect and have undermined the force of this decision. Perhaps, however, subsequent facts have placed this decision in its proper perspective. Where the issue is a medical one, namely the termination of useless therapy, that question is one which should be decided by the physicians, not by the courts. All the Court here had to do was find that such a medical decision does not violate the law.

The problem with the Quinlan case is that, according to the lower court, all the physicians agreed that the case was not hopeless. If this is a reasonable medical judgment, then one can only conclude that, in the collective mind of the New Jersey Supreme Court, and although unsaid, either the doctors were factually wrong in their conclusion or medically hopeless means "non-sapient or non-cognitive." What does this mean for the retardate?

If there is a lesson to be learned from the Quinlan case, it seems to me that one lesson is for the court to interfere less with medicine and to spend more time analyzing the legal issues involved, and in particular the impact those legal issues will have on other areas of the law.

Already we see the movement for the legalization of voluntary and involuntary euthanasia. Duff and Campbell have stated their case for the legalization of involuntary euthanasia in the special care nursery.¹⁶ In its provi-

sional report of Dec. 16, 1975, the Council of Europe draft recommendation by the Committee on Social and Health Questions opts for both voluntary and involuntary euthanasia of the incurably ill, or even those whose cerebral functions have irreversibly ceased.¹⁷ Certainly the Quinlan case should not be considered as a step in that direction since the Court takes great pains to distinguish between the substituted judgment of a parent or guardian to terminate medical treatment for an incompetent and the deliberate, intentional taking of another's life. However, one cannot but express the concern previously stated by Prof. Yale Kamisar in his famous article that the slippery slope once begun is indeed difficult to terminate, and where it will terminate is anyone's guess.¹⁸

The second and more important lesson should be learned by the medical profession. If that profession wants to avoid interference by the courts it ought to liaison with the bar to seek cooperation on these difficult issues long before litigation begins. Such liaison should be permanently institutionalized by the creation of a standing and funded committee composed of physicians, lawyers and moralists. This committee should be funded by the American Bar Association and the American Medical Association, although totally independent of either. It should have adequate staff.

The committee's main function should be the issuance of legal-moral-medical "opinions" on these and similar issues. Such "opinions" can be the result of study, research, and even testimony before the committee by interested persons. The moral persuasiveness of such "opinions" will depend on the prestige and impartiality of the committee. Certainly any such committee will experience the usual problems to which such institutions are heir, but its existence seems imperative to the current and future needs of both medicine and law.

REFERENCES

1. In the Matter of Karen Quinlan, Supreme Court of New Jersey, A-116, Sept. term 1975 decided 3/31/76, Slip Opinion pp. 1-59. (Hereafter all citations will be to the Slip Opinion.)
2. The doctrine of substituted judgment is being used in the special care nursery to allow parents the right to refuse consent to even ordinary means of treatment for defective children. See Duff and Campbell, *ft.* 16 *infra*.
3. It is reported that Karen was transferred to a nursing home "to spend her last days." *Chicago Daily News*, June 9, 1976, p. 2.
4. *Op cit.*, *ft.* 1 at p. 38.
5. *Idem.*, see also p. 33 ("in the exceptional circumstances of this case"); p. 38, p. 39.
6. *Op cit.*, *ft.* 1 at p. 39.
7. *Ibid.*, at p. 13 where the court said:
"It seems to be the consensus not only of the treating physicians but also of the several qualified experts who testified in the case, that removal from the respirator would not conform to medical practices, standards and traditions."
8. This ominous word appears twice on page 44:

- "The physicians in charge of the case, as noted above, declined to withdraw the respirator. That decision was consistent with the proofs below as to the *then* existing medical standards and practices. Under the law as it *then* stood, Judge Muir was correct in declining to authorize withdrawal of the respirator."
9. *Op. cit.*, ft. 1 at p. 45.
 10. See Judge Muir's opinion.
 11. *Op. cit.*, ft. 1 at p. 52, 53.
 - 11A. *Op. cit.*, ft. 1 at p. 13.
 12. *Ibid.*, at p. 54.
 13. *Ibid.*, at p. 54, 55.
 14. *Ibid.*, in court's footnote 9 at p. 55.
 15. Gorby, John, and Jonas, Robert E., "West German Abortion Decision:

A Contrast to *Roe v. Wade*," *The John Marshall Journal of Practice and Procedure*, Vol. 9, No. 3, Spring 1976, pp. 551-684 at p. 559, 560.

16. Duff and Campbell, "Moral and Ethical Dilemmas in the Special-Care Nursery," 289 *New Eng. J. Med.* 890 (1973).

17. Draft Recommendation presented by the Committee on Social and Health Questions, Council of Europe, Doc. 3699, Provisional Report of 12/16/75.

18. Kamisar, Yale, "Some Non-Religious Views Against Proposed 'Mercy Killing Legislation'," *Minnesota Law Review*, Vol. 42, No. 6, May 1958, pp. 669-1042.

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