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## I. INTRODUCTION

The question of euthanasia has been debated in medicine, law, and ethics for centuries. However, until recently the debate was largely confined to obscure professional journals with little impact on public policy,[1] and there were only a few who supported the idea. The founding of the British Euthanasia Society in 1935 served as a catalyst for bringing the matter to public attention in Britain; the founding of its American counterpart in 1938 had the same result in this country. The British society brought a bill authorizing mercy killing before the House of Lords in 1936, but the bill failed, as did a similar bill introduced in Nebraska in 1938 at the behest of the American group.[2]

For the next two decades the issue lay dormant. The practices of the Nazis were so deplorable that few wanted to be associated with anything appearing remotely similar. This twenty-year silence was broken in 1959 by the appearance of Glanville Williams' provocative book, *The Sanctity of Life and the Criminal Law*.[3] Williams frankly advocated the mercy killing of any adult requesting it, provided only that two physicians certified

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1. The literature on the historical contours is vast. For some survey material, most of it "pro-euthanasia" in tone see O. RUSSEL, FREEDOM TO DIE (1975); Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty without Classical Roots*, 8 HASTINGS CENTER REPORT 23 (1978); Reiser, *The Dilemma of Euthanasia in Modern Medical History* in THE DILEMMAS OF EUTHANASIA (J. Behnke & S. Bok eds. 1975); H. TROWELL, THE UNFINISHED DEBATE ON EUTHANASIA (1970).

2. H. TROWELL, *supra* note 1, at 13-22, discussing the debate in Britain in the 1930's as well as a more recent attempt to legalize mercy killing there in 1969. *See also* G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 329-50 (1957); YOUR DEATH WARRANT? (J. Gould & L. Craigmyle eds. 1971).

3. G. WILLIAMS, *supra* note 2. *See also* Curran, Book Review, 71 HARV. L. REV. 585 (1958); Donnelly, Book Review, 67 YALE L.J. 753 (1958). For an extended response see N. ST. JOHN-STEVAS, LIFE, DEATH AND THE LAW (1961). Though he was an English barrister, St. John-Stevas' criticisms were religiously premised.

him to be suffering from an "incurable" illness that would either cause him "severe pain" or render him incapable of leading a rational existence.[4]

The ensuing debate between Williams and his chief American antagonist, Yale Kamisar,[5] has often been cited as a classic. However, both writers, especially Kamisar, failed to bring forth the strongest arguments available for their respective positions. Williams' case rested on three arguments. First, he contended that the inconsistency between the law as written and the law as applied led to uncertainty among the very people whose actions in this respect ought to be governed by some legal structure.[6] Second, he maintained that the case against euthanasia was irremediably religious in character, rendering it deeply suspect as the basis of law and policy in a secular regime.[7] Finally, he argued that failure to enact euthanasia legislation forced individuals to lead lives of misery and suffering.[8] Of these three arguments only the last is persuasive.[9] To it Kamisar made two replies. First, he pointed out the possibility of mistake or abuse in applying a euthanasia policy. For example, the required diagnosis could be wrong, or the patient could be allowed to make this choice when he was in a de facto state of incompetency as a result of sedative drugs.[10] Second, Kamisar pointed out that the legal system created under Williams' proposal would cover classes or persons who, while meeting the required standard, were incapable of giving consent (e.g., the retarded and the insane).[11]

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4. G. WILLIAMS, *supra* note 2, at 345.

5. Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958); *but see* Williams, *Euthanasia Legislation: A Rejoinder to the Non Religious Objections*, 42 MINN. L. REV. 1043 (1958).

6. G. WILLIAMS, *supra* note 2, at 318-33.

7. *Id.* at 311-18.

8. *Id.* at 333-50.

9. Williams' claim of inconsistency in application is one that applies to almost all criminal law, given the inability to catch most criminals. For example, very few, if any, professional "hit men" are ever caught. Does this mean we should stop regulating this sort of behavior because of an inconsistency in law as written and as applied? His argument about religiousness fares no better. Most legislation touches upon the religious claims of some group. Race relations would be a good example. Surely Williams would not want to claim that all attempts to outlaw overt racial segregation were wrong because they involved the state enforcing one religious view against another which held that segregation was ordained by God. As Williams himself admitted, Kamisar produced substantial, nonreligious objections to mercy killing proposals. Such objections seem to render the religiousness argument unpersuasive.

10. Kamisar, *supra* note 5, at 985-1013.

11. *Id.* at 1015-41. The Williams-Kamisar debate raised crucial issues, but it did not state them in a very compelling form. This is particularly true of Kamisar's second argu-

In the last two decades, proposals such as Williams' have gained a handful of supporters who have expressed their views in professional literature.[12] However, no court has seen fit to overturn the common and statutory law against murder on request, and although a few bills reflecting Williams' position have been introduced in state legislatures, they have received little support. Most of the discussion currently revolves around the right of individuals to have life-saving or life-prolonging therapy removed or withheld.[13] It is this right that is now being pressed in state legislatures, courtrooms, and legal, medical, and philosophical journals.[14] It is in fact the current policy goal of the

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ment. Kamisar likened the move to legalize mercy killing to the early measures of the Nazis; he feared the same results would follow. As other commentators have pointed out, *see, e.g., supra* note 1, this is not a very sound argument. In order to predict that these dire consequences would result, one would need to show that our culture, history, legal tradition, and circumstances were compellingly similar to those of Germany in the 1930's. No one has yet done this convincingly, and barring this demonstration, the argument fails. M. KOHL, THE MORALITY OF KILLING, 98-99 (1973); G. WILLIAMS, *supra* note 2, at 345.

Beneath the surface, however, is a much stronger argument. For the comparison above to have force, one need not predict that the retarded and the insane will actually be disposed of; one need only show that the position taken logically leads to that result if the law is applied fairly to all similar cases. *Cf.* P. TAYLOR, PRINCIPLES OF ETHICS 95-105 (1975); Sherlock, *Selective Non-Treatment of Defective Newborns: A Critique*, 7 ETHICS IN SCIENCE AND MEDICINE 111 (1980). The requirement that the law apply equally to similar cases is the core of any stable legal system, E. PATTERSON, JURISPRUDENCE 97-116 (1953); L. FULLER, THE MORALITY OF LAW (1968); Sherlock, *Liberalism and the Life Not Worth Living; Abraham Lincoln on Beneficient Euthanasia*, 26 AM. J. JURIS. (1981) [hereinafter cited as Sherlock, *Liberalism*], and if a given proposal cannot meet such a test of fair application without repugnant results then the proposal must be discarded. This is a route that Kamisar did not take, but it is eminently sound and it will be employed freely in this Article. It represents the kind of thinking that ought to precede all law and policy whether legislatively, judicially or administratively enunciated. Unfortunately, as will be noted, more than one author or legislator has drafted proposals that fail this minimal test.

12. *See, e.g.*, D. MACGUIRE, DEATH BY CHOICE (1974); M. KOHL, *supra* note 11; Russel, *supra* note 1; Comment, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALBANY L. REV. 826 (1975); Steele & Hill, *A Plea for the Legal Right to Die*, 29 OKLA. L. REV. 328 (1976); Delgado, *Euthanasia Reconsidered*, 17 ARIZ. L. REV. 474 (1975); Morris, *Voluntary Euthanasia*, 45 WASH. L. REV. 239 (1970).

13. *See infra* cases discussed in text accompanying notes 82-188.

14. Literally hundreds of articles have discussed the issues surrounding the removal of life-sustaining medical therapy. For reviews of the discussion with good references to the literature see R. VEATCH, DEATH, DYING AND THE BIOLOGICAL REVOLUTION (1976); G. GRISEZ & J. BOYLE, LIFE AND DEATH WITH LIBERTY AND JUSTICE (1979). *See also* DEATH, DYING AND EUTHANASIA (D. Horan & D. Mall eds. 1975); ETHICAL ISSUES RELATING TO LIFE AND DEATH (J. Ladd ed. 1980); BENEFICIENT EUTHANASIA (M. Kohl ed. 1975). An even more wide ranging debate has taken place with respect to the propriety of removing life-sustaining measures or withholding life-saving therapy from newborn infants born with severe handicaps. Many of these children need extensive medical care to save their

leading association in the field.[15]

Whether such a right is to be given statutory force and what form that right should take are crucial issues because they strike at two rights long thought to be central to a liberal polity; the equal and inalienable right to life irrespective of its condition and the freedom to live one's life as one prefers. The more theoretical aspects of this tension have been discussed elsewhere.[16] This Article will review the issues presented by the various proposals for establishing the right to die. It will demonstrate the profoundly problematic character of much that is said in their defense. Finally, it will review current law and legislative proposals, attempting to provide a comprehensive synthesis that will preserve as much individual liberty as possible without leading into far more treacherous legal and policy waters.

However, before analyzing the current proposals, it will be helpful to clarify some of the crucial distinctions that are raised when the right to die is considered.

## II. Preliminary Distinctions

### *A. Voluntary/Nonvoluntary*

The voluntary/nonvoluntary distinction refers to the question of consent. Voluntary decisions are those made by the patient himself. Nonvoluntary decisions are made for an incompetent person by someone else. It is often asserted that the distinction between voluntary and nonvoluntary decisions is of crucial significance when the right to die is discussed.[17] But it is difficult to see why this should be so. In the closely analogous situation of homicide the consent of the victim is not a defense. Mercy killing is simply a form of homicide, with little to distinguish it significantly from the more common varieties.

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lives. In many cases their lives can be saved but they will remain severely handicapped both physically and mentally. The treatment of such children is beyond the scope of the article except insofar as analogies may be drawn between incompetent adults and severely retarded children for purposes of pointing out the logical extension of any proposed policy.

15. Society for the Right to Die, Legislative Manual: 1979-80.

16. Sherlock, *Liberalism, supra* note 11.

17. For example, Kamisar places great importance on the supposed danger of sliding from voluntary to nonvoluntary euthanasia. Most of the recent literature stresses the importance of patient consent, suggesting the importance of the distinction between voluntary and nonvoluntary forms of the right to die. *See, e.g.*, Note, *Euthanasia: Criminal, Tort, Legislative and Constitutional Considerations*, 48 Notre Dame Law. 1202, 1222-23 (1973).

However, one might wonder if there is something about the withdrawal of life-saving treatment which would make the distinction between voluntary and nonvoluntary decisions more meaningful in that situation. Although many writers have thought so, their proffered rationales are uncompelling.[18] In order for such a distinction to be meaningful with respect to the withdrawal of treatment, the individual's assessment of his situation and the individual's choice must be deferred to in every situation, even when the individual is extremely distressed and disturbed. Otherwise, society must decide which choices from which patients deserve respect. Such a decision will inevitably require society to decide that in a given range of cases it would not be reasonable to withdraw therapy. Once society decides that it can determine when it is reasonable to withdraw therapy, there seems to be no justification for excluding, *a priori*, a decision made by the family of the incompetent patient.[19]

This conclusion is reinforced by the recent court decisions

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18. In a recent essay James Rachels has suggested that mercy killing be made a legally acceptable justification for killing a person which a defendant may present in his behalf similar to the offering of a "self-defense" defense to a homicide charge. This would mean that the defendant would have to prove the competent consent of the patient to his being killed. This, of course, assumes the importance of the distinction between voluntary and nonvoluntary euthanasia. It is, however, an extraordinarily weak proposal. It assumes two very problematic propositions: (1) that every competent patient's request should be honored and (2) that competency can be assessed independently of the reasonableness of the act which the agent or his friend proposes to undertake. The first point is necessary, for if the one who is to "pull the trigger" is to make an independent assessment of reasonableness, that will directly involve him in a judgment concerning whether his friend has a life worth living. The vagaries and often plain absurdities attending this judgment in recent literature are dealt with below. The second presumption cannot be fully treated here, but it too cannot withstand serious analysis. It is, of course, flatly rejected in the common law of suicide intervention. Moreover, if competency is regarded, as Rachels wishes to do, as a threshold beyond which the choice of the patient must be respected, this sort of abstraction from his actual choice will not do. It is extremely unlikely that we would seek to honor the request of someone who wished to be drawn and quartered, or who wished to have his hands cut off (but not to die) as appropriate punishment for some crime. I submit that our refusal to honor such requests would have little to do with the mental state of the individual who makes such a request except insofar as the request itself is viewed as evidence of mental disturbance. James Rachels, *Euthanasia*, MATTERS OF LIFE AND DEATH (T. Regan ed. 1981); on the competency question see also, Sherlock, *Suicide and Public Policy: A Critique of the New Consensus*, 3 BIOETHICS Q. ___ (1981) (at press).

19. The family's role is still very problematic. If society has decided that it knows when family consent would be reasonable, problems arise when a family demands treatment even though the physician believes it to be unreasonable. Would these demands need to be respected? Would the physician need a court order before withholding the treatment in order to avoid future liability?

discussed below.[20] The courts have all sought to grant the same rights to competent and incompetent patients with respect to the withdrawal of treatment. Thus, they implicitly deny the meaningfulness of any distinction between voluntary consent and nonvoluntary decisions made by third parties.[21]

### *B. Active/Passive*

The active/passive distinction is, for some commentators, the most controversial.[22] For others it is a sound division with an established pedigree in common law and common usage.[23] Generally it refers to the difference between a situation in which a physician actively induces a painless death and one in which he merely withdraws or withholds life-saving therapy. This distinction is thought to be important in establishing the duty and liability of a physician who must decide whether to continue treating a patient, especially a comatose patient.

The right of the physician to treat an incompetent patient is clear.[24] Further, when a competent patient requests that the physician withhold life-saving therapy, the question of suicide arises.[25] Yet, even when the scope of the active/passive distinction is thus restricted, it is difficult to establish a coherent, legally defensible difference between misfeasance and nonfeasance. Members of an incompetent's family do not have the authority to request that the physician actively induce the incompetent's death, even if the incompetent is in great distress.[26] The question, then, is whether a distinction can be made between this request and a request that the needed medical therapy be withdrawn.

The cogency of any such general distinction is difficult to sustain. For example, consider the hypothetical situations of *A* and *B*. *A* is a person with severe brain damage and paralysis. He is not dead and is not dying. He is alert but his brain damage renders him clearly incompetent to choose appropriate medical

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20. *See infra* text accompanying notes 117-88.

21. *Id.*

22. For a review of many of the issues that arise when the active/passive distinction is considered, see KILLING AND LETTING DIE (B. Steinbeck ed. 1980).

23. *E.g.*, G. GRISEZ & J. BOYLE, *supra* note 14; R. VEATCH, *supra* note 14.

24. The only exception would seem to be when a court permits family members to refuse therapy for one of their number.

25. *See infra* text accompanying notes 37-50.

26. Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213 (1975).

care for himself. The family, believing his life to be worthless, requests the physician to end it painlessly. *B* is an elderly patient with dementia (rendering him incompetent). He becomes seriously ill from an infection. The family, believing that his life is not worth living, requests the physicians to withhold antibiotics, knowing that this will lead to a spreading of the infection and death. In terms of the jurisprudence of homicide, there seems to be little that differentiates these two situations. The general ban against homicide reflects society's fundamental choice not to allow one man to decide that another will not live any more. Absent the extreme exigencies of self-defense or the very controversial punishment for capital crimes, our society grants an equal minimal right to each life, regardless of its status or defects. Such a choice may be disputed, but to dispute it is to dispute the whole rationale for the legal prohibition of homicide in liberal regimes.[27] If the concept of the equal minimal worth of each life is in fact essential to our legal and constitutional framework, the cogency of any general distinction between the situations of *A* and *B* above cannot be sustained. In both situations a third party has made a decision that the affected patient should not live any longer.

Furthermore, if a physician agrees to the request of either *A* or *B*, he can justify his decision by either choosing to assent to the family's decision or by asserting that their choice ought to be respected. Sanctioning the first position—that the doctor can assent to a family's decision that one of its members ought to die—would entail a more fundamental revision of the law of homicide than anyone has yet proposed. Even then it would not necessarily provide a coherent distinction between the two cases.[28] Sanctioning the second position is no better. A physician's assertion that he knows when a family's request to terminate a member's life should be honored would be based on the presumption that he knows when the normal constraints of the law regarding homicide should not apply, i.e., that he knows when the individual's life is not worth living and thus not within the scope of the law's protection. Such a justification would require an analysis of the intent of either the physician or the

27. *Cf.*, Sherlock, *Liberalism*, *supra* note 11. For the fundamental basis of this assertion see J. LOCKE, THE SECOND TREATISE OF GOVERNMENT, para. 6 (London 1690); J. HOBBES, LEVIATHAN (London 1651).

28. If every case is to be decided on the basis of respecting the choice of the patient or his family, then in both cases the family's choice should be respected.

family. Since intent can be presumed from the natural consequences of the act, such an analysis would lead directly to an application of the legal prohibition of homocide.[29] Thus, what would be required is an investigation of actual intent, an investigation that is largely beyond the competence of the legal system.[30]

Once the possibility of analyzing intent is set aside, the question of whether withholding life-saving treatment might be usefully classified as an "omission" becomes irrelevant. Such an action deviates from the accepted standard of care that patients expect from their physicians. Furthermore, a fundamental professional rule appears to require that the physician save lives when possible.[31] It is hard to imagine a more profound violation of this rule than a physician's failure to act or to continue acting which results in death. Distinguishing such action from actions constituting culpable negligence would then rest on the possibility of showing that something about the act of withholding treatment distinguishes it from acts that clearly constitute negligence.[32] The physician's actions or the family's wishes are plainly incapable of sustaining such a distinction. Unless the "double intent" principle[33] is used, the only possible justification for treating the withholding of treatment differently than other negligence would be to claim that the patient is in some condition that renders continued care unreasonable. To date, the

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29. "[A] person is presumed to intend the natural and probable consequences of his acts." Dulap v. United States, 70 F.2d 35, 37 (7th Cir. 1934). *See also* R. PERKINS, CRIMINAL LAW 747-48 (1968); RESTATEMENT (SECOND) OF THE LAW OF TORTS § 8a (1965) (those consequences of an act which the agent knows are "substantially certain to be produced" are presumptively designated as intended, irrespective of the "desires" of the agent).

30. The law's inability to determine actual intent is the basis for its traditional reliance on behavior (and the consequences of behavior) for determining intent. *See generally* RESTATEMENT (SECOND) OF THE LAW OF TORTS (1965).

31. For example, the foundation of medical ethics, the Hippocratic oath, provides: "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel." Hippocratic Oath. *See* H.B. JACOBS, THE SPECTRE OF MALPRACTICE 416-17 (1978).

32. The physician is liable if he fails to provide reasonable care for the patient, as measured by the care provided by similar physicians in the same area. This specifically includes omissions. S. PEGALIS & H. WASCHMAN, AMERICAN LAW OF MEDICAL MALPRACTICE § 2.5 (1980); I.D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 8.06 (1977). *See infra* text accompanying notes 60-64.

33. Under the theory of double intent, an agent is not responsible for a foreseen but unintended consequence of his action. This theory is disputed and is not part of the common law.

quality of life criteria required to make such a decision have proven to be so elusive, vaguely stated, and dangerously elastic in their logical applications that they simply could not be given statutory permanence in any fair way.[34]

### C. *Suicide/Homicide*

The two established legal categories into which euthanasia may fit are homicide and suicide. It is widely recognized that the state has an inherent right to attempt to prevent either.[35] Thus, unless they wish to mount a wholesale attack on the established restrictions of suicide and homicide, those who wish to legalize some form of euthanasia have only two courses open to them. First, they may show that, although the activity in question is properly classified as suicide or homicide, it should be permitted as an exception to the established prohibitions. Second, they may dispute the classification of the activity as homicide or suicide. In either situation, clear lines must be drawn between the prohibited and the permitted activities—a very difficult task.

Active mercy killing is universally classified as homicide, even with the victim's consent.[36] Therefore, proponents of eu-

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34. Sherlock, *Liberalism, supra* note 11; Sherlock, *Selective Non-Treatment of Defective Newborns: A Critique,* 7 ETHICS IN SCIENCE AND MEDICINE 111 (1980).

35. At common law, suicide was self-murder and was thus prohibited by the law of homicide. Over the last two centuries all criminal punishment of suicide and attempted suicide has ceased. But this transformation was not the result of a new belief that the state had no business in interfering with suicide. Rather the view was the criminal sanctions are either ineffectual or unwise. In the case of completed suicide criminal sanctions cannot reach the offender (if he is classed as such). They can only affect his family or friends with such measures as forfeiture of the estate (the common-law penalty in England for centuries). As for attempted suicide, the newer recognition was that such people need psychiatric help, not a jail term. Still, the right of the state to interfere with and prevent a suicide attempter from completing his deed is clear and written into the statutes of every American jurisdiction. The use of force to prevent suicide is given explicit sanction in the Model Penal Code § 3.07(5). *See also* A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 700 (1974); Shulman, *Suicide and Suicide Prevention: A Legal Analysis,* 55 A.B.A. J. 855 (1968); Note, *Punishment of Suicide—A Need for Change,* 14 VILL. L. REV. 463 (1969).

In a number of cases the courts have either stipulated or argued that refusal of life-saving treatment is not suicide and have either stated or implied that were it so defined the state would have a compelling reason to intervene. *See, e.g.,* Application of the President and Board of Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964); John F. Kennedy Medical Center v. Heston, 58 N.J. 576, 279 A.2d 670 (1971); *cf.* Reynolds v. United States, 98 U.S. 145 (1878).

36. G. WILLIAMS, *supra* note 2, at 318; Wechsler & Michael, *A Rationale of the Law of Homicide,* 37 COLUM. L. REV. 701 (1937). Wechsler and Michael clearly view mercy killing as homicide but they argue that it should be classed as an exception to the nearly universal legal proscription of homicidal acts. *See also* R. PERKINS, *supra* note 29, at 31.

thanasia must show that it constitutes an exception to the general proscription of homicide. Such an exception must be created in a way that will not eviscerate the general rule. But an attempted limitation of the euthanasia exception to situations in which the victim consents would be overly narrow, given the supposed rationales for mercy killing. That is, a victim of a painful injury or disease who is permanently incapable of consent would be a prime candidate for euthanasia, and it is difficult to see how the alleged humanitarian ideals of euthanasia could be served by keeping him alive. Those who defend mercy killing have recognized this point and have generally sought to include comatose patients in their proposals. To date, however, none of the advocates of euthanasia has succeeded in drafting a mercy killing proposal that would not also logically apply to the chronically insane and the retarded, who also cannot consent, but are not considered proper subjects of mercy killing. It is difficult to understand how anyone in our moral, legal, and political tradition could endorse such a proposal.[37]

The attempts to justify passive euthanasia differ in approach from those used to justify active mercy killing. Most courts and commentators have sought to diminish passive euthanasia from suicide rather than attempt to show that it constitutes a form of suicide for which the established prohibitions should not apply. Consequently, they have argued that permitting passive euthanasia need not affect the state's legal right to intervene in suicide attempts in general.[38] However, as a rule, the asserted distinctions have been completely spurious. As the court in *John F. Kennedy Memorial Hospital v. Heston*[39] noted:

> Appellant suggests there is no difference between passively submitting to death and actively seeking it. The distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug. If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other. It is arguably different when an individual, overtaken by illness, decides to let it run a fatal course. But unless the medical option itself is laden with the risk of death

37. P. RAMSEY, ETHICS AT THE EDGES OF LIFE (1977); Sherlock, *Euthanasia as Public Policy*, 1981 POL. SCI. REVIEWER.

38. *See* R. VEATCH, *supra* note 15, at 96-99; Byrn, *Compulsory Life Saving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1 (1975). Some authors do link the two together. G. GRISEZ & J. BOYLE, *supra* note 14; Lebacqz & Englehardt, *Suicide*, in DEATH, DYING, AND EUTHANASIA 649 (D. Horan & D. Mall eds. 1975).

39. 58 N.J. 576, 279 A.2d 670 (1971).

> or of serious infirmity, the State's interest in sustaining life in such circumstances is hardly distinguishable from its interest in the case of suicide.[40]

This argument is entirely sound, regardless of whether it was directly applicable to the facts in *Heston*.[41] Consider the following situations: *A* is elderly and now confined to a wheelchair. He concludes that life is not worth living and begins to refuse to eat, saying, "life just ain't worth it anymore." *B* is elderly and needs to have his leg amputated in order to save his life. He refuses, saying that if he is confined to a wheelchair, "life won't be worth living."

It is very difficult to see how any coherent, principled distinction can be made between these two situations. In both situations the individual intends to die solely because he believes that in his present condition life is not worth living. Neither one is dying; both deaths could be prevented. Both patients have clearly set in motion a process that will end in their death. Assertions that patients such as *B* simply wish to "defer to the vagaries of life" or that "[i]t is not they, but the natural progress of their ills which will destroy their lives"[42] are simply wrong. Those who make these assertions overlook the crucial fact that the person has decided to die. "Nature" has made no such decision for this person. The course that "nature" will take is almost wholly determined by the parties involved. If such assertions were true, the state's right to prevent suicide would be undermined, because it can just as easily be claimed, for example, that it is not the person himself, but rather the loss of nourishment, that kills the person who stops eating.

Some commentators attempt to distinguish suicide from euthanasia on the basis of the personality characteristics of the people involved.[43] It may be true that some suicidal persons are aggressively "waging war on themselves," but such psychological theories have never been crucial in classifying an act as suicidal, either at law or in clinical practice. And in some situations, like the one involving *A* above, such a characterization is not appropriate.

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40. *Id.* at 481-82, 279 A.2d at 672-73.

41. The question of intent might be crucial in a situation like *Heston*, but in *Heston* the patient was unconscious. Therefore, intent or lack of it had to be judged from the statements of her family and friends.

42. Byrn, *supra* note 38, at 20.

43. *Id.* at 16-20.

Finally, it should be pointed out that many believe that suicide cheapens life because it denies the value of each life:

> It may be argued, with at least some validity, that actively killing oneself disvalues human life, *qua* human, because it constitutes aggression against life. Suicide treats human life as property which may be destroyed or alienated at the will of the "owner," contrary to the principle that since life is unalienable, one may not be allowed to cause or consent to his own destruction.[44]

If this is true, any proffered distinction between *A* and *B* collapses. *B* clearly has decided that his life will be worthless, that it has no value any more, at least in the condition in which he would be forced to live it. These are precisely *A*'s feelings as well. If intervention is justified on *A*'s behalf because of the intrinsic value of human life, then a similar rationale ought to apply to *B*, for the problem asserted is the same—a person decides that his life is not worth living and he acts on that belief. This is a judgment that a liberal society cannot permit because it cheapens life. The prohibition of self-induced death must be followed across the board; to do otherwise would be to violate minimal standards of fairness.[45]

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44. *Id.* at 20-21.

45. The above analysis stands regardless of the importance given to the concept of the patient's intent. Whether his intent is disregarded, as often happens in the law, or considered important, the similarity between the consequences of the patients' acts in the two situations is obvious. Furthermore, the state's traditional authority to intervene in suicide attempts is based on "presumed intent," the state deferring to clinical authorities for the analysis of actual intent. This is surely the soundest course to take, given the difficulties in judging intent.

The argument set forth in the text above is not undermined by Professor Fletcher's oft-cited proposal to treat the withdrawal or withholding of life-saving therapy as an omission of the physician governed by the "samaritan standard" under which a physician can withdraw or withhold therapy without liability unless he holds a special relationship with the victim. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967). Omitting for a moment the situation in which the family requests the withdrawal, a situation which may give rise to a special relationship, Fletcher's proposal is defective in several respects. First, it focuses entirely on the liability of the physician, not on his right to intervene or the patient's right to request withdrawal. These are difficult issues that Professor Fletcher's proposal does not reach. Even on its own ground the proposal is inadequate. As shown by many of the cases at notes 116-87, *infra*, the typical patient is not a complete stranger whom the physician may ignore without liability. The decision to withdraw or withhold treatment is usually made after an extensive period of hospitalization, after diagnostic and therapeutic measures have been carried out. The decision to withhold treatment in such circumstances is analogous to the following situation: A car held by a rope is parked on a steep hill. *A* cuts the rope, and the car rolls down the hill, damaging both the car and *B*'s house at the end of the hill. It seems clear that *A* will be held liable

Although it may be true that conventional thought does not consider the refusal of treatment to be suicide, what is necessary in this inquiry is a clear, coherent distinction between the two classes of euthanasia, active and passive, and clarity and coherence are qualities not likely to be found in the loose vagaries of common discourse.[46] The means chosen to bring about death plainly cannot sustain such a distinction. The "passive" refusal of food in the depressed person or in the hunger striker is every bit as much a cause of death over which the person has control as is the proverbial bottle of barbiturates. If the person has a nonfatal illness, his capacity to decide whether he lives or dies, or his guardian's capacity to so decide, is substantial and is something for which the individual who makes the choice is surely responsible.

What then of the concept of intent? The law is generally incapable of looking at intent except by way of an analysis of observed behavior and its consequences. As noted before, this is explicit in the case of tort law.[47] The consequences which a reasonable man could have foreseen are presumptively defined as intended. It is hard to see how the law could do otherwise without engaging in extraordinarily vague discussions of various

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for his action, regardless of the relationship between himself and *B*, or between himself and the owner of the car. The similarity between that situation and one in which a life-sustaining respirator is removed is obvious, and Professor Fletcher's ingenious analysis fails. Under "emergency" or "observational" commitment standards, which exist in the vast majority of states, mental health professionals, not courts, are given the responsibility of sorting out the problems of the suicidal person, including his true intent. A. BROOKS, *supra* note 35, at 751-53 (1974).

46. In a recent analysis Beauchamp has tried to differentiate between suicide and the refusal of treatment but his reason for so doing seems little more than obiesance to the vagaries of conventional thought. In the end he is incapable of providing any such rigorous, coherent distinction. He admits that the intention of the agent may be the same in both cases. He also admits that the "passivity" of the one will not be sufficient to distinguish it from suicide where the agent's intention is the same. Still he believes that generally it can be said that one who refuses treatment is not the cause of his death while the suicide usually is. On some theories of human action this might be correct, but for legal purposes it is plainly specious. The question is not one of action theory, but of responsibility. If the question is put in these terms the answer seems plain—in both cases the agent is responsible for his death. It was plainly within his capacity to choose either life or death for himself. His choice of death is something for which he surely is responsible. This is the only way to square such situations as these with long-established principles in analogous situations. For example, if a parent fails to provide medically necessary life-saving care for his child he is liable for the child's death and may be convicted of neglect. If he refuses antibiotics for pneumonia it is the parent who is responsible for the death of the child, not the invading bacteria in the child's lungs. T. BEAUCHAMP, MATTERS OF LIFE AND DEATH 67-108 (1980).

47. *See supra* notes 26-33 and accompanying text.

mental stages. Even in criminal law the situation does not change greatly. One remembers with caution the difficulties in defining the differences between the various classes of murder and manslaughter in terms of the subjective intent of the agent.[48] In most of these cases intent has come to be judged from behavior because in practice there is little alternative. Furthermore, we must note that the fundamental judgment—that a criminal act which society can proscribe has occurred—is judged not from intent but from the fact that a person is now dead as a result of some human act.[49]

Thus, it is impossible to establish any systematic, coherent legal differentiation between suicide and the refusal of clearly life-saving medical therapy. In all legally relevant particulars the individual who refuses to take nourishment is no different than the person who refuses treatment. There may be ways in which the two cases can be distinguished on philosophical or psychiatric grounds, but these have never been accepted as part of the common or statutory law of suicide.[50]

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48. *See* especially R. PERKINS, *supra* note 29, at 28-82. Generally manslaughter is a species of homicide which would be murder at law except for the absence of the necessary intent.

49. The Model Penal Code provisions are instructive in this regard. The fundamental wrong is the killing of the human being, or the assisting in such killing. The only relevant distinctions are: (1) those few cases where the killing may be justified as in self-defense, or (2) those distinctions among various classes of homicide for purposes of affixing proper punishment. In this case the various mental and external circumstances of the act are relevant for determining whether the individual is to be tried for murder or manslaughter. But in both cases the wrongful act remains and the right of the state to convict and punish is certain with or without the presence of homicidal intent on the part of the agent. As argued in the text, however, in most cases of active or passive euthanasia we are dealing with a plain intent on the part of the one making the request (patient or proxy) to bring about death. At the very least this is true absent a theory of "double intent" which is foreign to the law. *See* Model Penal Code § 210.

Furthermore, at the point at which the law is most centrally concerned with intent, namely, in deciding whether a person is guilty of the offense he is charged with, the judgment is almost entirely made on the basis of observed behavior. As a matter of evidence, behavior and its consequences are the crucial matters, rather than an investigation of the mental state of the accused. This is especially true in homicide cases where the act is presumed to be unlawful until the defendant proves otherwise.

> Intent is a state of mind which can be evidenced only by the words or conduct of the person who is claimed to have entertained it . . . . Thus when a person without any provocation strikes another with a deadly weapon or throws a corrosive acid in his face and thereby maims or disfigures him, he is presumed to have intended to maim or disfigure because that was the natural and probable consequence of his act.

Banovitch v. Commonwealth, 196 Va. 210, 216, 83 S.E.2d 369, 373 (1954). *See also* 9 WIGMORE, EVIDENCE §§ 2491, 2511a (Chadbourne rev. 1981) (citations omitted).

50. The attempts by courts and commentators to distinguish in clear, coherent

### *D. Terminal/Nonterminal Patients*

The previous analysis suggests that society cannot make any efforts to legalize the removal of life-saving medical technology without calling into question the fundamental premises of a free society and the established legal response to homicide and suicide. To a certain extent this is undoubtedly true. Nevertheless, there is at least one important group of patients whose situation is so different that the problems noted above do not arise when passive euthanasia is considered for them. This group consists of the terminally ill—patients who will die regardless of what is done medically. The only crucial question in regard to their situation is when death will occur. The more general distinction between active and passive euthanasia makes sense with respect to this class. When a physician treats someone who is terminally ill, his actions will determine whether the patient will die sooner or later, but, in deciding to stop treatment, the physician does not decide that this patient ought to die from a certain pathological process; that matter has already been determined by forces beyond the control of either the patient or the physician.[51]

The difference between a terminal and nonterminal patient

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terms active and passive euthanasia from suicide on the one hand and homicide on the other seem unsustainable on inspection. This is especially true in the case of passive euthanasia where the attempts to produce a coherent distinction between homicide in the case of the incompetent patient and suicide (and assisting in suicide) on the part of the competent patient simply don't work. To return to the analogy of the car for a moment (*see supra* note 45), if a severely retarded person in the car were killed when it crashed at the bottom of the hill the person who cut the rope would be legally and morally responsible for his death. If, like the physician, he knew that this would be the result of his act he would clearly be guilty of homicide. To date no court or commentator has come to grips with the deep-seated similarity between this sort of case and that of patients tethered to life by the apparatus of the hospital.

On the other hand, if the owner of the car, having despaired of life, were to ask a bystander to cut the tethering rope with him in it, knowing the crash would be fatal and hoping to deceive his family and insurer into believing his death to be accidental, the death would clearly be suicide, and the bystander would be guilty of assisting in a suicide. Again the similarities to the case of the patient are obvious. In neither case have the necessary distinctions been made in a compelling manner by anyone.

The only way to distinguish the two cases would be to employ the controversial principle of double intent. However, even this theory would fail to provide the necessary support for a distinction because there would still be a need to distinguish those cases in which this principle may be employed to absolve someone of responsibility from those in which it may not. Even those who believe the principle to be sound philosophy have recognized this shortcoming, and, accordingly, they have adopted a similar policy for suicide and voluntary passive euthanasia. *Cf.* G. GRISEZ & J. BOYLE, *supra* note 14.

51. *Cf.* P. RAMSEY, PATIENT AS PERSON 113-64 (1970); Sherlock, *Liberalism, supra* note 11.

is a crucial distinction with a respected pedigree in common law and common language. To illuminate its contours, consider the decision to remove a respirator from a patient. If the patient is not terminally ill, it is legally correct to say that the doctor caused the patient's death by removing the respirator. He did not merely permit death to occur. The harm would not have occurred were it not for his actions.[52] If, on the other hand, the patient is terminal, the situation changes. It becomes a situation in which the patient is permitted to die. It is in this situation that it is proper to discuss the legal category of omission and the reduced or eliminated legal liability that results.[53]

More significantly, there are important policy reasons for recognizing the terminal/nonterminal distinction. When the patient is terminal, neither the agent nor those who regulate his activities need be concerned with the hopelessly elusive question of whether life is worth living. It is enough merely to concede that an individual need not prolong his dying process.[54] On the other hand, when the nonterminal patient is chronically ill, debilitated or comatose, the question of euthanasia inevitably requires society to either struggle with insoluble problems of statutory drafting, or to remove all legal prohibition of suicide or assisting in suicide when the affected individual or his family concludes that life is no longer worth living. The former alternative logically leads to repugnant advice concerning the lives of several hundred thousand severely retarded persons, and the latter displays a similar insensitivity to the situation of depressed and disturbed persons.

By limiting itself to terminal patients, most current legislation avoids these problems. Thus, this legislation is preferable to the broader alternatives advanced in professional literature.[55] Such a limitation does not place the question of whether a person lives or dies in the hands of third parties. It permits society to go as far as it can go without calling into question a set of

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52. This "sine qua non" test is highly significant and it is stressed by many writers. Nevertheless, applying the test in some situations causes problems. *See* H.L.A. HART & A. HORORÉ, CAUSATION IN THE LAW (1959). The use of the test in the above situation does not cause the problems discussed by Hart and Hororé.

53. Professor Fletcher is ambiguous on this point. Sometimes he writes as though he were limiting the application of his analysis to cases in which the patient is terminal. If this were the case his position would resemble the one in this Article. Nevertheless, at other times he seems to argue for a broader position. *See* Fletcher, *supra* note 45.

54. P. RAMSEY, *supra* note 51.

55. *See infra* text accompanying notes 190-96.

beliefs about the worth of individual lives and a set of common-law traditions that embody those beliefs. These beliefs and traditions are at least as deeply rooted as anything to which the devotees of the right to die can appeal in support of their recommendations.

Having clarified some of the basic distinctions that often arise when the right to die is discussed, we will now turn to the current proposals for euthanasia that have been advanced in professional literature, case law, and statutory enactments. As will be shown, these proposals are overly vague and create problems which cannot be left unresolved.

## III. Professional Literature on Euthanasia

The professional literature concerning euthanasia is in some ways the most distressing material examined in this Article. One would think that since the scholars who write these articles enjoy both the time and the training necessary to reflect on the central issues of jurisprudence, law, and policy which arise when euthanasia is considered, they would provide a sustained and probing inquiry, coupled with sober practical recommendations. Unfortunately, for the most part, this has not been true. Instead, they present unsubstantiated claims and vague and ill-conceived recommendations for statutory enactments. A brief review of this literature will delineate its deficiencies and outline the main problems with which this Article deals.

The voluminous legal materials concerned with the right to die have largely been of two types. First, there are those articles that deal only with the legal aspects of the right to die. Some of these comment on one specific case (e.g., *Quinlan*) in which a court has raised and discussed the issues.[56] Since by design these articles do not raise broad legislative or policy issues, they will not be discussed here. Other purely legal articles argue for the enactment of a "right to die" either by legislative-minded courts or, more properly, by legislatures themselves.[57] Some of these ar-

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56. *E.g.*, Smith, *In re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 Tulsa L.J. 150 (1976); Symposium, "In re Quinlan," 30 Rutgers L.J. 243 (1977).

57. *E.g.*, Kapner, *Proposed State Euthanasia Statutes: A Philosophical and Legal Analysis*, 3 Hofstra L. Rev. 115 (1975); Smyth, *Antidysthansia Contracts*, 5 Pac. L.J. 738 (1974); Vodiga, *Euthanasia and the Right to Die*, 51 Chi[-]Kent L. Rev. 1 (1974); Note, *The Living Will: The Right to Death with Dignity*, 26 Case W. Res. L. Rev. 485 (1976); Comment, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 Ind. L.J.

ticles propose that the already acknowledged liberty to refuse a physician's advice be expanded to include the right to withdraw from or refuse life-saving medical care. The writers of these articles wish to see this freedom include the right of any patient to refuse any therapy, even if he has not been diagnosed as terminally ill. They also argue that family members should be able to decide such matters for an aging parent or small child.[58]

The second group of legal materials is made up of articles that seek to demonstrate the acceptability of the "right to die" in its pristine sense. The authors of these articles contend for the right to have oneself or one's child killed whenever the life in question is believed to be meaningless or miserable.[59] These authors base their arguments on general legal or moral principles concerning privacy and autonomy, and many propose statutes legalizing mercy killing, either for adults or children.

Although these two groups of legal materials differ from one another, they manifest a common narrowness of vision. The articles begin with what the author believes is an important legal assumption (e.g., the right to privacy), or sometimes simply his own value preference (e.g., claims about how awful life is for the severely retarded). Working from these assumptions, the author then seeks to demonstrate how the law could be used to fashion a "proper" response to the right to die, that is, a response that agrees with his preferences. The chief weakness of these legal materials is their failure to deal with fundamental questions of jurisprudence and public policy. This weakness can be revealed by analyzing some representative examples, beginning with those articles which advocate the outright legalization of mercy killing.

In two important articles Arval Morris, Professor of Law at the University of Washington, has defended mercy killing for both adults and children.[60] In his first article, Morris advocates the acceptance of "voluntary euthanasia" only, by which he means killing a person when that person requests it, or at least when he has previously executed a written legal document stating that if he is ever in a certain condition he wishes to be killed.

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539 (1976).

58. Child euthanasia is not discussed in this article.

59. *See* Delgado, *supra* note 12; Morris, *supra* note 12; Steele & Hill, *supra* note 12; Comment, *supra* note 12.

60. Morris, *supra* note 12; Morris, *Law, Morality and Euthanasia for the Severely Defective Child,* in INFANTICIDE AND THE VALUE OF LIFE 137 (M. Kohl ed. 1978).

However, in his second article, in which he defends the killing of infants and children, Morris abandons the voluntary consent requirement. It therefore appears reasonable to conclude that Morris would be willing to apply the same logic to incompetent adults, i.e., if society knows a person's "life is not worth living," it has a right to terminate it. Morris maintains that since these people cannot communicate their desires, it ought to be presumed that they would be "reasonable" and that they would want that which is "good" for them.

But who are these people who can be benefitted from being killed? Morris states that a "qualified patient" is one whom two physicians certify to be in an "irremediable" condition, and he defines that condition thus:

> "[I]rremediable condition" means either (1) a serious physical illness which is diagnosed as incurable and terminal, and which is expected to cause a person severe distress, or to render him incapable of a rational existence, or (2) a condition of brain damage or deterioration such that a person's normal mental faculties are severely and irreparably impaired to such an extent that he has been rendered incapable of leading a rational existence.[61]

This definition is so poor as to be astonishing as part of a proposed law. Nowhere is the key concept "rational existence" defined with any precision. No clear lines are drawn to distinguish between acceptable and unacceptable behavior. No clear guidelines are offered for those who will have to implement the law. The physician forced to make a decision under this statute finds nothing except vague language about the lack of a "rational existence" and the suffering involved in such a life. How physicians are to make such a choice is never explained, nor is the more important question of why they should make it at all explored. After all, there is nothing in a physician's usual training that enables him to know anything about the deep philosophical questions of the nature of a "rational existence" and the meaning of life. Modern politics and jurisprudence have systematically excluded these questions from public life. They may be discussed publicly, but only as matters of personal preference or religious opinion—not as matters of law or public choice. Morris, however, wishes to adopt some public standard, the "rational existence" standard, as a *sub rosa* limitation on the pre-

61. Morris, *supra* note 12, at 267.

sumed equal minimal worth of each human life. Instead of allowing all men to be endowed with the right to life, Morris would limit that right to all men not determined by a pair of doctors to be incapable of a rational existence. In this sense, Morris and his followers wish to take a path that the founders of liberalism specifically rejected.[62]

Unfortunately, Morris seems oblivious to the serious implications of the fundamental departure from our political and legal tradition which he endorses. In the absence of any generally accepted concept of a "rational existence," those who implement the statute must rely on their own resources—their own religious opinions, personal experiences, and even prejudices. This leads directly to the most profound injustice possible in a liberal regime—the refusal to treat similar cases similarly. If in similar circumstances one pair of physicians decides one way under Morris' proposed law and another pair decides another way, it would not be even minimally fair. Morris ignores the history of human experience and the recent empirical data that suggest that such unfairness is almost certain to occur under his law,[63] and he offers no way to avoid it or even minimize its effects. Furthermore, Morris' standard would logically include hundreds of thousands of retarded and chronically insane persons who are demonstrably incapable of a "rational existence" under any plausible definition of that term. The possibility that this group could be eliminated under Morris' proposal is, perhaps, the most telling objection to his plan, an objection to which Morris provides no answer. A proposal that authorizes the elimination of this group departs so radically from our moral, legal, and political tradition that it is impossible to see how it can be endorsed.

In essence Morris gives the policymaker or the legislator what he wants most—a model he can copy. But nowhere does he give the legislator what he *needs* most—a transcendent analysis of the deepest political issues at stake in this problem. What the legislator needs is a complete understanding of the choices before him and their relationship to the regime in which he leg-

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62. Sherlock, *Liberalism, supra* note 11.

63. D. CRANE, THE SANCTITY OF SOCIAL LIFE (1976). Crane found that the physician's prevailing basis for making judgments concerning the withdrawal or withholding of care was his individual assessment that a particular person could not live a "useful life" any longer, even with treatment. In an unpublished paper Joy Skeel and Ron Benson have documented an extraordinary degree of variation among physicians in making these judgments. Skeel & Benson, *Medical Indications for Postponing Death* (1979) (unpublished address to the American Academy of Religion, New Orleans, La.).

islates. Without this, Morris' recommendations remain removed from the real needs of society. Yet they remain dangerous precisely because of their superficial character. They are easily understood and they are specific, two qualities that may tempt legislators into using them.

Morris' recommendations are representative of those being made in legal and policy-oriented journals. Some writers offer no standards for the application of mercy killing at all. They merely argue for the repeal of all legal restraints on suicide and assisting in suicide, and claim that every person has the right to dispense with his life whenever he wants.[64] Their only caveat is that a court hearing should be held to determine that the person "knows what he is doing."[65] Other authors merely assert that there is a "fundamental right" to choose death whenever one wants. They argue that anyone should be able to terminate his life for any reason. These authors maintain that denying a person the ability to exercise this right violates liberty, and that, like denying a woman the right to an abortion, it "consigns an individual to a life he does not choose to lead."[66] However, this right to choose death over life has never been recognized by the common law. In fact, it was rejected by the founders of liberalism.[67] The authors of these articles simply ignore the questions that the liberal tradition should lead them to address.

The articles just noted all defend active mercy killing. They are on the far edge of the current discussion regarding the "right to die." More restrained and more numerous are those articles devoted to the analysis and defense of some version of the so-called "living will" in which an individual declares in advance that under certain conditions he wishes to have medical care withheld or withdrawn. The literature defending the propriety of enforcing such a document and the policy that underlies it is enormous. Nevertheless, in the rush to deduce from other "rights," such as liberty or privacy, a policy favorable to their personal preferences, the authors of these articles, like their more extreme counterparts, ignore the more fundamental questions at stake.

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64. Steele & Hill, *supra* note 12; Comment, *supra* note 12.

65. Steele & Hill, *supra* note 12; Comment, *supra* note 12.

66. Delgado, *supra* note 12. *See also* Forkosch, *Privacy, Human Dignity, Euthanasia—Are These Independent Constitutional Rights?*, 3 U.S. FERNANDO VALLEY L. REV., No. 2, 1 (1974).

67. Sherlock, *Liberalism*, *supra* note 11.

Consider what may still be the best single article on the subject, one written by Professor Norman Cantor.[68] His review of the statutory and common-law principles relevant to the question of the right to die is useful and often penetrating. His constitutional commentary is sound, if legalistic. The argument he advances is really quite simple: Since at least one aspect of personal liberty, religious conscience, is often involved in these situations, and since another right, privacy, as defined by the courts, is arguably present in every such situation, there must be some public interest at stake before society can interfere with a personal choice to refuse life-saving medical care.[69] Cantor discusses several public interests that could override this personal choice, rejects them all as not universally applicable, and concludes that except when specific harm to a third party would otherwise result, state interference with the choice to die is both unwise as policy and forbidden by constitutional mandate.[70]

However, one of the interests rejected by Cantor—the so-called "sanctity of life"—is a crucial societal interest, and Cantor's failure to effectively explain why such an interest is not overriding renders his more practical conclusions untenable. Cantor admits that the sanctity of life is not merely a vague theological tenet but is in fact "the foundation of free society."[71] But Cantor merely asserts this truth. He does not demonstrate why and how it is true, nor what its truth implies about public policy and law in a free society. Had he undertaken this further investigation, he might have seen the problematic nature of resolving the tension between life and liberty in favor of liberty.

The most insidious assault on the principle of the sanctity of life occurs when a society legally recognizes a standard that defines some lives as not worth the same kinds of protection that are afforded the lives of the rest of that society's members.[72] Nevertheless, Cantor's proposal leads directly to this result, unless he is willing to argue that society must respect an individual's expressed choice for death in every conceivable situation. If Cantor does not sanction such universal respect, he must either tell us when these choices need to be respected, or

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68. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973).

69. *Id.* at 236-54.

70. *Id.* at 243-44.

71. *Id.* at 244.

72. *See* Sherlock, *Liberalism*, *supra* note 11.

he must let the courts develop a common-law standard for making that determination. Neither alternative is particularly attractive given the complex philosophical questions that would have to be resolved if such a standard were set up.

Cantor seems to be led astray by his own analogy to religious martyrdom.[73] This is an easy mistake to make since the most notorious instances of refusal of life-saving medical care have often involved sincere religious devotees.[74] Yet it is a mistake to think that most situations in which life-saving medical care is refused involve the noble ideals of religious conscience. The more common situations involve people who simply do not wish to live anymore or those who have been sold on quackery. Perhaps society should respect their choices as well, but Cantor's analogy to religious devotion does not provide any reason for doing so.

The same defect appears in Cantor's attempt to distinguish the refusal of life-saving medical care from suicide.[75] Prima facie, the two appear very similar; both involve a person with an intent to die. Nevertheless, Cantor argues that they are, in most instances, quite dissimilar. First, he contends that suicide usually stems from some form of mental illness.[76] The mental disorder produces either a rash desire to die or a distorted cry for help. In either instance the decision to commit suicide, distorted as it is by the person's mental disorder, is hardly worthy of respect. Such is not the case with respect to the refusal of medical treatment, Cantor argues, since the refusal is usually motivated by religious conviction. However, this distinction is empirically unproven and theoretically unpersuasive. It is unlikely that Cantor would sanction a policy of nonintervention when a "Jim Jones" instructs his "religious" followers to kill themselves. Thus, not all who chose to die out of a purported religious devotion merit the respect and sanction of society.

Moreover, as Cantor admits, there are those whose suicidal acts are every bit as sincere as those of the conscientious religionist who refuses medical treatment. Cantor is thus led to conclude that the liberty of the sincere suicide ought to be respected.[77] Unfortunately, this policy of selective suicide is al-

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73. Cantor, *supra* note 68, at 238-46.
74. *Id.*
75. *Id.* at 254-58.
76. *Id.* at 256.
77. *Id.* at 258.

most certainly incapable of transformation into statutory form. Further, even if such a statutory standard could be formulated, it would still be necessary to develop some criteria for deciding when the intention to die is reasonable (i.e., when it is reasonable to conclude that life is not worth living). The development of such criteria would be a direct repudiation of the supposed inalienable right to life that even Cantor seems to admit is crucial in a liberal regime.[78]

If Cantor's troubled resolution of the problem of suicide is problematic, his discussion of mercy killing is patently inconsistent with the position he takes with respect to that issue. He claims to be bothered by any policy that would legalize mercy killing, even at the victim's own request.[79] Adopting such a policy, he admits, would entail a wholesale revision of the criminal law, which has heretofore held that the consent of the victim is not a defense. Furthermore, it would require official recognition of the worthlessness of some lives. Despite these damaging admissions, Cantor considers the case for voluntary mercy killing "appealing," and he cannot offer any coherent reason for opposing it, except his own professedly idiosyncratic uneasiness.[80]

Given this sheer relativism, it is not surprising that Cantor cannot find any principled distinction between what he proposes and the killing of the sick and the debilitated. All he can do is note that the law considers mercy killing to be murder, while at least some courts approve of the right to refuse life-saving medical care. By extension, Cantor argues that society ought to respect all decision to refuse treatment, from anyone, for any reason.[81] However, Cantor also believes that since mercy killing remains illegal, society should respect that judgment too. This is positivism at its worst. Unable to offer any principled distinction between the two situations, Cantor distinguishes them by falling back on the fact that, perhaps inconsistently, contemporary jurists consider them different.

Cantor's article is clearly superior to most of the other literature on the subject. Even he, however, displays major weaknesses on both substantive and policy grounds. Substantively, Cantor's analysis is weak because his failure to probe his own contention that the "sanctity of life" is fundamental in a free

78. *Id.* at 261.
79. *Id.*
80. *Id.* at 260.
81. *Id.* at 263.

society leads him to overlook the way in which his own proposals contradict the essence of that principle. He merely states that the sanctity of life principle is important, never offering any serious articulation of the meaning of the principle or the ways in which it is important or ought to be reflected in policy. On the policy level, Cantor fails to provide what any good legal proposal must provide—substantive guidance to those who must act on his recommendations.

The euthanasia proposals found in the professional literature have generally been overly vague and unsupported by persuasive analysis. Because these proposals deal with such important and complex issues, society should be hesitant to embrace them unless these weaknesses are corrected. An analysis of the case law and statutory enactments and proposals reveals that in a liberal society it may be impossible to overcome these weaknesses without fundamentally undermining society itself.

## IV. Case Law on Euthanasia

The case law with respect to euthanasia is scattered and uneven in quality. The recent, widely publicized cases discussed below are only the most visible portion of a larger series of cases involving mercy killing and the refusal of life-saving treatment.

### *A. Active Euthanasia Cases*

The mercy killing or active euthanasia cases may be noted very briefly. The principles of law relevant to their resolution are well established and uncontroversial. The consent of the victim or his family (if he is incompetent) has never been a defense to a homicide charge. Accordingly, it has not been permitted as a defense in active euthanasia cases. Neither has the victim's suffering or quality of life been relevant.[82] However, courts and juries in active euthanasia cases have generally found technical or somewhat fanciful rationales for refusing to mete out the punishments normally attached to homicide. Alternatively, the perpetrators have been found temporarily insane,[83] unlikely to com-

82. *See* Kamisar, *supra* note 5, at 1019-23. This is also true in the cases involving children. Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 Stan. L. Rev. 213 (1975).

83. *See* Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 Notre Dame Law. 1213-14 (1973) (discussing the *Zygmaniak* case); Braunsdorf, N.Y. Times, May 23, 1950; Paight, N.Y. Times, Feb. 8, 1950; Greenfield, N.Y. Times, May 12, 1939.

mit a future offense and therefore not in need of punishment,[84] or not guilty because the victim was arguably dead and it could not be proved beyond a reasonable doubt that the defendant's action was in fact homicide.[85] In some of these cases the result was sound. In others, the legal doctrines were apparently stretched to reach a result compatible with the gut feeling of the judge or jury.[86]

### *B. Cases Involving the Right to Refuse Life-Saving Treatment*

The issues at stake in cases involving a patient's refusal of life-saving treatment are much more controversial. Most importantly, the question of whether such actions fall within the scope of permissible individual liberty or impermissible self-destruction is at stake. However, in most of the cases decided so far, unique facts or issues have obscured this central issue and permitted resolution on other grounds.

#### *1. Pre-1975 Cases*

In *Ericksen v. Dilgard,*[87] the patient refused a blood transfusion, even though he was willing to permit an operation to stop intestinal bleeding. Whether the blood was immediately necessary to sustain life or whether it was needed merely as a precautionary measure is not clear form the record. The court refused to order a blood transfusion, but given the lack of clarity on the crucial medical facts, it was able to sidestep the petitioner's claim that Dilgard was committing suicide. "The Court cannot agree with that argument because it is always a question of judgment whether the medical decision is correct."[88]

In *Powell v. Columbian Presbyterian Medical Center,*[89] the patient refused to authorize blood transfusions following blood loss during a Caesarian section. As a result she had been placed on the "danger list" at the hospital. The patient, Mrs. Powell,

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84. *See* Gurney, *Is There a Right to Die?*, 3 CUM.-SAM. L. REV. 235 (1972) (discussing the *Werner* case); Williams, *Euthanasia and Abortion,* 38 COLO. L. REV. 178 (1966).

85. *See* Gurney, *supra* note 84 (discussing the *Sander* case); N.Y. Times, March 10, 1950. *See also* R. VEATCH, *supra* note 14, at 78 (discussing the *Montemorano* case).

86. Suspended or commuted sentences have also been common. *See* Kamisar, *supra* note 5, at 1019-23.

87. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

88. *Id.* at 28, 252 N.Y.S.2d at 706.

89. 49 Misc. 2d 215, 267 N.Y.S.2d 250 (Sup. Ct. 1965).

did not object to receiving blood; she objected only to giving authorization, believing that her culpability before God hinged on whether she consented to the transfusion. Quite reasonably, the court took its cue from Mrs. Powell and ordered the blood.[90]

Mrs. Powell was the mother of six children, a fact that was not determinative in her case but which was crucial in *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson.*[91] In *Anderson,* the female patient carried a full-term fetus, and it was clear that she would require blood during delivery. There was a high likelihood that the mother or the child or both would die during delivery without the blood. The lives of the mother and child were so inseparable that the court ordered the transfusion, relying on established precedent concerning the state's right to intervene on behalf of a child.

In several cases the incompetency of the person involved required the court to decide not only the patient's right to refuse treatment but the rights of the family in such matters as well. In the widely discussed case of *Application of the President and Directors of Georgetown College, Inc.,*[92] the court held that an incompetent patient could be transfused on an emergency basis even though her religious beliefs would forbid it and even though it was being refused by her husband, a coreligionist.[93] Petition for rehearing on appeal was denied since by then the patient had been discharged from the hospital.[94] The court's decision appears to have been motivated by two concerns. First, the patient required a series of transfusions over a period of days, but the immediate issue was a matter of life or death. A limited order would permit further consideration of the question by all parties and would leave the patient free to refuse treatment again or to re-petition the court at any point in the series of treatments.

> The temporary order issued was more limited than the order proposed in the original application, in that the phrase "to save her life" was added, thus limiting the transfusions in both time and number. Such a temporary order to preserve the life of the patient was necessary if the case were not to be mooted

90. *Id.*

91. 42 N.J. 421, 201 A.2d 537 (1964). *But see In re* Osborne, 294 A.2d 372 (D.C. 1972).

92. 331 F.2d 1000 (D.C. Cir. 1964).

93. *Id.* at 1001-02.

94. Application of President & Directors, 331 F.2d 1010 (D.C. Cir. 1964).

> by the death of the patient.
>
> At any time during the series of transfusions which followed, the cause could have been brought on for hearing by motion before the motions division of the court, and the order either vacated, continued, or superseded by an order of a more permanent nature, such as an interlocutory injunction. Neither the patient, her husband, nor the hospital, however, undertook further proceedings in this court or in the District Court during the succeeding days while blood was being administered to the patient.[95]

The second crucial factor motivating the court's decision was that the husband's refusal appeared to be very similar to that of Mrs. Powell, a distinction being made between consenting to the blood and being forced to take it.[96] In addition, the court quite properly raised the question of self-destruction (suicide or religious martyrdom). It concluded, however, that Mrs. Jones did not wish to die and that she was therefore not suicidal.[97]

In *John F. Kennedy Memorial Hospital v. Heston*,[98] the nature of the patient's and family's refusal to permit blood tranfusions was different from that in *Powell* or *Georgetown*. In *Heston*, the patient was unconscious, but her religious beliefs precluded her from receiving any transfusion in any context. The superior court ordered a transfusion. The Supreme Court of New Jersey, while finding that the case was technically moot, decided to resolve it as a matter of public interest.[99]

Although the court's resolution of the case is somewhat confusing because its analysis misses the central features of the case, the opinion does raise several crucial questions. The court found that the state's interests in preserving life and preventing suicide were broad enough to cover the facts presented. This is arguably not the case, as the court admits.[100] Nevertheless, the court's analysis is absolutely correct—there is no constitutional right to commit suicide, regardless of the religious sincerity of the person. Furthermore, the court dismissed the legally spurious distinction between passively submitting to death and ac-

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95. 331 F.2d at 1003.
96. *Id.* at 1006-07.
97. *Id.* at 1009.
98. 58 N.J. 576, 279 A.2d 670 (1971).
99. *Id.* at 579, 276 A.2d at 671.
100. *Id.* at 582, 276 A.2d at 672-73.

tively killing oneself.

> Appellant suggests there is a difference between passively submitting to death and actively seeking it. The distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug. If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other. It is arguably different when an individual, overtaken by illness decides to let it run a fatal course. But unless the medical option itself is laden with risk of death or of serious infirmity the state's interest in sustaining life in such circumstances is hardly distinguishable from its interest in the case of suicide.[101]

This analysis is entirely sound, notwithstanding that it is unrelated to the key issue in *Heston,* the question of the agent's competency.

A second line of the court's analysis in *Heston* concerns the prerogatives of the hospital and its personnel. The court describes the hospital and its personnel as involuntary hosts of this patient. As such, their interests in maintaining their own professional integrity could be pitted against the interests of the patient. This was especially true in *Heston* since the family made no effort to move the patient elsewhere.[102] Combining this factor with its more compelling analysis of the suicide issue, the court chose for Mrs. Heston's life.

The leading case in which the right of a competent patient to refuse life-saving treatment is explored most clearly and directly is *In re Estate of Brooks.*[103] In *Brooks,* the mother of adult children refused blood transfusions on religious grounds; a decision supported by her husband and children. The patient suffered from a peptic ulcer and was to undergo surgery. The extent of her need for blood was unclear. Nevertheless, the court clearly treated this as a life and death matter.[104]

The trial court ordered the transfusions, which were made, and Brooks appealed. On appeal the Illinois Supreme Court held that the case was not moot and overturned the lower court. The cases discussed above were all rejected because in *Brooks* the patient was neither incompetent nor the parent of minor children, nor was there any question of her being willing to have

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101. *Id.* at 581-82, 276 A.2d at 672-73.
102. *Id.* at 582-83, 276 A.2d at 675.
103. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).
104. *Id.* at 362, 205 N.E.2d at 438.

blood without actually consenting to it.[105] The decision hinged, according to the court, on religious freedom. With the issue framed in that manner, the court confronted a long line of cases concerning a person's religious views with respect to compulsory vaccination,[106] polygamy,[107] and snake handling,[108] in which an absolute right to act in accord with religious beliefs was rejected. In an attempt to distinguish these precedents, the court asserted that they all involved public morals or safety, concerns that are within the permissible scope of the state's power, irrespective of the question of religious motivation.[109]

Unfortunately, the court nowhere confronted the issue raised in dictum in *Reynolds v. United States*,[110] the leading polygamy case. What if religious convictions dictate suicide? The *Reynolds* court answered correctly; religious belief must give way at that point.[111] It is hard to see how the activities of a private suicide cult would be any more a matter of public morals than the question at issue in *Brooks*. Yet common and statutory law give the state the right to intervene in the case of suicide.

The court's reliance on a first amendment claim in *Brooks* is unhelpful for two reasons. First, it does not help resolve the cases which involve no religious beliefs. Second, it allows the court to cite an entirely inapposite series of cases involving flag salutes,[112] pledges of allegience,[113] and school prayer.[114] These cases all contain dicta nobly defending religious freedom, but given the issues they dealt with, none of them needed to confront the right of the individual to deliberately injure or kill himself under the cover of religious belief. Citing these cases only obscures the central conflict of constitutional values at work in cases such as *Brooks*.

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105. *Id.* at 372-73, 205 N.E.2d at 439-40.

106. Jacobsen v. Mass., 197 U.S. 11 (1905).

107. Reynolds v. United States, 98 U.S. 145 (1878).

108. Lawson v. Commonwealth, 291 Ky. 437, 164 S.W.2d 972 (1942); Harden v. States, 188 Tenn. 17, 216 S.W.2d 708 (1948).

109. 32 Ill. 2d at 367-68, 205 N.E.2d at 439-40. The court's reading of the two "snake handling" cases is wrong. The courts in both cases explicitly referred to the harm that might come to the handler irrespective of the harm that might come to the audience. *See* Note, *Unauthorized Rendition of Life-Saving Medical Treatment*, 53 CALIF. L. REV. 860 (1965).

110. 98 U.S. 145 (1878).

111. *Id.* at 166-67.

112. W. Va. St. Bd. of Educ. v. Barnette, 319 U.S. 624 (1943).

113. *Id.*

114. School Dist. v. Schempp, 374 U.S. 203 (1963).

The decision in *Brooks* may represent the trend in these sorts of cases.[115] If so, it is an ill-thought-out trend, one that allows a court to rely on stretched precedents and factual quirks to avoid a fundamental decision on the state's right to prevent an individual from deliberately taking steps that will inevitably entail his own destruction.

### *B. Case Law Since 1975*

Since 1975 major court decisions on the "right to die" have been rendered in five states: New Jersey, Massachusetts, New York, Delaware, and Florida. The contours of these cases, both factually and legally, reveal much about the types of cases that occur and the legal system's competency to handle them.

#### *1. Case Law in New Jersey*

The earliest of the post-1975 New Jersey cases was the celebrated decision of *In re Quinlan.*[116] The case involved a twenty-two year-old woman in a permanently comatose state. Although she required a respirator, she exhibited enough brain activity that she could not properly be classified as "brain dead." Medically, however, she had no hope of regaining neurological functions beyond those required for maintaining vegetative body systems.[117] Quinlan's parents initially sought to have the physicians remove what they believed was an artificial and extraordinary life support system, and they did so with the full support of their religious leaders. When the hospital and the physicians refused, the parents sought recourse in the courts.

At trial the issue was essentially one of guardianship. Two questions were central: (1) Was the patient's father, Joseph Quinlan, competent to act as Karen's guardian? and (2) Did his powers as guardian include the right to order the respirator removed and to take the necessary steps to see that this was done? The trial court held for Mr. Quinlan on the first issue, but against him on the second. The trial court framed the second issue in terms of the "right to die" and necessarily concluded

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115. *See* Byrn, *supra* note 38, at 10-13.

116. 70 N.J. 10, 355 A.2d 647 (1976).

117. *Id.* at 24, 355 A.2d at 654. Brain death requires the cessation of all brain activity, not just that of the higher brain functions as in *Quinlan.* For a review of these issues see Veith, *Brain Death 1: A Status Report of Medical and Ethical Considerations,* 238 J. AM. MED. A. 1651 (1977); Veith, *Brain Death 2: A Status Report of Legal Considerations,* 238 J. AM. MED. A. 1744 (1977).

that no such right existed in the common or constitutional law, nor in the statutory law of New Jersey.[118]

On appeal the Supreme Court of New Jersey reversed the trial court with respect to the second point. To reach its conclusion, the state supreme court relied on the most overworked and inappropriate right imaginable—the right of "privacy."

> If a putative decision by Karen to permit this noncognitive, 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 the qualification hereinafter stated, 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.[119]

The use of the concept of privacy was unnecessary. What the court actually wished to hold was that a right previously held by Karen Quinlan, namely, the right to refuse medical care, was not, *a priori,* terminated by her incompetency. However, privacy is not the appropriate right to apply in such a situation. Even if the rationale for giving a right of privacy constitutional status is accepted, it surely does not apply in *Quinlan.* The respirator is hardly an intrusive medical procedure, and Karen was not involved in intimate bedroom activities. There was nothing private about her situation or the procedures being refused. Further, the family's involvement made the decision even less private.[120]

By relying on the right of privacy, the court masked what may be its most disturbing claim—that Karen's life should be ended because it is worthless. The court attributed such a wish to Karen herself, but it admitted that it had absolutely no factual basis for doing so. What the court was really claiming is that if Karen were reasonable she would end her life, since her life is no longer worth living. The idea that Karen Quinlan's life

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118. *In re* Quinlan, 137 N.J. Super. 227 (1976).
119. 70 N.J. at 41-42, 355 A.2d at 663.
120. *Id.*

was to be ended because it was worthless was central to the court's decision. The court sought to distinguish *Quinlan* from its earlier decision in *Heston* by relying on this idea.

> We have no doubt, in these unhappy circumstances, 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. To this extent we may distinguish *Heston*, . . . which concerned a severely injured young woman (Delores Heston), whose life depended on surgery and blood transfusion; and who was in such extreme shock that she was unable to express an informed choice (although the Court apparently considered the case as if the patient's own religious decision to resist transfusion were at stake), but most importantly a patient apparently salvable to long life and vibrant health;—a situation not at all like the present case.
>
> We have no hesitancy in deciding, in the instant diametrically opposite case, that no external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life.[121]

Reliance on the idea that Karen Quinlan's life was worthless may be the only way to explain the *Quinlan* decision, as disturbing as that idea is. Karen was not dead and she was not dying. The medical procedure involved was almost routine; it was certainly not extraordinary except in a specifically religious sense of that word. The court did not reject *Heston*. It merely asserted that Karen's choice would be respected because the court believed it to be reasonable. The implication of the court's position is clear. If there had been even a chance that Karen would regain sentience the court would not have deferred to her parents' wishes, nor to the wishes of Karen herself (if *Heston* stands). The court simply used the only vaguely applicable right it could conceive of in an effort to justify legally what it believed was best morally—the release of Karen from her "unendurable"[122] existence. The arbitrary nature of such claims has been discussed earlier and need not be reviewed here.[123]

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121. *Id.* at 39, 355 A.2d at 663.

122. *Id.*

123. *See supra* text accompanying notes 59-63; Sherlock, *Liberalism*, *supra* note 11.

The court's claim that if Karen were "reasonable" she would want the respirator turned off is also open to serious question. Karen was incapable of suffering and the unanimous opinion of the experts who testified was that she was not in pain except when specifically subjected to painful stimuli for purposes of neurological tests. One wonders therefore why anyone in her condition should find it reasonable to want to die. However small it may have been she did have some chance of a miraculous recovery. Absent the usual reasons for choosing death, pain and suffering, it seems clear that the conventional "rational man" of economic and legal theory would not necessarily have found it logical to choose to turn off the respirator. To be sure, Karen's family and friends did suffer tremendously through her ordeal. In this sense it may have been an act of moral courage for Karen to have chosen to remove the respirator to relieve them of this burden. But this version of her choice adopts one among many theories of moral decision and cannot be derived from the understanding of pure rationality which is endemic to the "rational man" test.

Upon finding that Karen would be better off dead and that Mr. Quinlan should be empowered to bring about this end, the court might have ceased its deliberations, leaving to the legislature the task of finding an appropriate means of ensuring that in the future others could exercise such rights. However, the court required that Quinlan, and others in similar circumstances, submit their cases to a hospital committee, inappropriately titled the "ethics committee."[124] The committee is actually a neurological committee that certifies the patient's hopeless neurological condition. Once the irreversible nature of the patient's loss of consciousness has been duly certified, Mr. Quinlan, or other guardians of similar patients in the future, would be free to take the steps necessary to remove the patient from the respirator.[125]

Unfortunately, the *Quinlan* court gave little coherent guidance in this uncharted area. It obviously believed that Karen's life was awful, but it offered no idea of how awful a human life must be before it reaches the threshold of "unendurability." Seeking to draw upon the established doctrine of "substituted judgment," the court attempted to attribute desires to Karen when the only basis for doing so was its own assertion that this

124. 70 N.J. at 49-51, 54, 355 A.2d at 668-69, 671.
125. *Id.* at 51, 355 A.2d at 669.

was what a "reasonable" person would want. In its effort to buttress its decision by recourse to the concept of privacy, the court was forced to note the intrusiveness of the medical procedure,[126] but it gave no guidance on how intrusive a medical procedure must be before it becomes a matter of privacy. Mr. Quinlan sought removal of the respirator. He has not, to date, sought removal of the feeding tube that provides nourishment to his daughter. Would this fall in the same category of "intrusiveness"? Anyone reasonably analyzing the two procedures would be hard pressed not to reach such a conclusion. In short, the court in *Quinlan* failed to provide guidance on most of the crucial issues at stake and thus failed in the central task of the judiciary in such matters.

### 2. *Case Law in Massachusetts*

The most controversial of the major cases has been the leading Massachusetts decision, *Superintendent of Belchertown State Hospital v. Saikewicz*.[127] The factual situation in *Saikewicz* was fairly simple. Joseph Saikewicz was sixty-seven and had been cared for in an institution all of his life because of his profound retardation. He could only communicate with grunts and groans. Saikewicz was discovered to have leukemia, and decisions about treatment necessarily followed. The probate court appointed a guardian ad litem and, after a hearing, concluded that

> Saikewicz's illness was an incurable one, and that although chemotherapy was the medically indicated course of treatment it would cause Saikewicz significant adverse side effects and discomfort. The guardian ad litem concluded that these factors, as well as the inability of the ward to understand the treatment to which he was being subjected and the fear and pain he would suffer as a result, outweighed the limited prospect of any benefit from such treatment.[128]

The Massachusetts Supreme Court upheld this decision, although the written opinion was not issued until nearly eighteen months later, after Saikewicz had died. The court concluded that given his right to be free from "non-consensual invasion of his bodily integrity," and his right of privacy, Saikewicz had a

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126. *Id.* at 41, 355 A.2d at 664.
127. 373 Mass. 728, 370 N.E.2d 417 (1976).
128. *Id.* at 729-30, 370 N.E.2d at 419.

right to refuse any therapy, absent a compelling justification for preventing him from doing so.[129] Four such justifications were considered and rejected by the court: (1) the preservation of human life, (2) the protection of third parties, chiefly minor children, (3) the prevention of suicide, and (4) maintaining the integrity of the health profession.[130] The court found none of these justifications applicable, concluding that Saikewicz's right to refuse therapy stood. The problem was that Saikewicz was incompetent to assert such a right. The court thus relied on the equality of human dignity in both competent and incompetent persons to conclude that similar rights must exist for both persons. It then proceeded to develop the contours of this right and the procedures necessary for its assertion by incompetent patients.[131]

The court held that the contours of the right to refuse therapy were broad; any medical therapy could be withdrawn or withheld. However, the court also held that before that right could be asserted for an incompetent person, some standard for reviewing the guardian's judgment had to be developed. At this point the coherence of the court's position breaks down entirely. At first the court discussed the commitment to Saikewicz's best interest, given his situation.[132] Subsequently, it discarded this test in favor of a wholly fictitious search for what Saikewicz would choose if he could. This "substituted judgment" test, however, simply does not work in this situation. The court had absolutely no basis for asserting anything about Saikewicz's wishes. The available data concerning other persons of his age group suggested that a clear majority would choose therapy,[133] a fact which the court noted and rejected:

> Saikewicz was profoundly mentally retarded. His mental state was a cognitive one but limited in his capacity to comprehend and communicate. Evidence that most people choose to accept the rigors of chemotherapy has no direct bearing on the likely choice that Joseph Saikewicz would have made. Unlike most people, Saikewicz had no capacity to understand his present situation or his prognosis.[134]

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129. *Id.* at 740-43, 370 N.E.2d at 425-26.
130. *Id.*
131. *Id.* at 745, 370 N.E.2d at 427.
132. *Id.* at 751-53, 370 N.E.2d at 431.
133. *Id.* at 750-51, 370 N.E.2d at 430.
134. *Id.* at 749-50, 370 N.E.2d at 430.

The truth is that the only course open to the court under this substituted judgment test was to choose what it believed was good for Saikewicz. In making this determination, the court considered a number of factors, concluding that two sets of facts were crucial. First, Saikewicz's retardation meant that he would suffer the side effects of therapy without understanding what was happening to him.

> Patients who request treatment know the risks involved and can appreciate the painful side-effects when they arrive. They know the reason for the pain and their hope makes it tolerable. To make a worthwhile comparison, one would have to ask whether a majority of people would choose chemotherapy if they were told merely that something outside of their previous experience was going to be done to them, that this something would cause them pain and discomfort, that they would be removed to strange surroundings and possibly restrained for extended periods of time, and that the advantages of this course of action were measured by concepts of time and mortality beyond their ability to comprehend.[135]

By considering this factor, the court flatly rejected its own announced goal of excluding the person's quality of life from its deliberation.[136] By making Saikewicz's suffering under treatment a crucial consideration, the court plainly suggested that Saikewicz's life would be more miserable than the lives of the majority, who, it admitted, would choose therapy. This misery justified the court in choosing for Saikewicz a course of action it believed others would not choose.

The court was forced to consider such features because of the way it framed the issues involved. By adopting an expansive view of the right to refuse therapy, the court prevented itself from concluding that Saikewicz would refuse the treatment because it would not actually save his life, but merely prolong the dying process, or because the treatment would not definitely save his life. Either of these is arguably a sound conclusion from the facts presented, but the court plainly wished to impose no such restriction on the right in question.[137] The court wanted to

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135. *Id.* at 750, 370 N.E.2d at 430.

136. *Id.* at 754, 370 N.E.2d at 432.

137. *Id.* at 731-33, 370 N.E.2d at 423-27. It is not at all clear the treatment would save Saikewicz's life. The prognosis for adult leukemia is much lower than for childhood leukemia. In fact, the chances of life-saving therapy for Saikewicz were substantially below fifty percent.

formulate a broad right to refuse any therapy at all, a right available even when the therapy could save the patient's life.

The court's position in *Saikewicz* is, in a curious way, symmetrical. Rejecting the limited right found in the "living will" legislation, the court espoused a broader liberty, one that includes the right to make decisions based on the quality of life, i.e., decisions to forgo treatment solely because life is worthless or miserable.[138] Wishing to extend this right to the incompetent patient, the court was surely not wrong on its own terms in allowing third parties to make these frank quality-of-life judgments for incompetent persons, even in the absence of any indication of what the incompetent person would want. Of course, the broader policy question of the propriety of allowing third parties to make choices for death when a majority of competent persons faced with analogous choices would not so choose was never discussed. Nor was the logical extension of such a policy to hundreds of thousands of retarded persons afflicted with ills ranging from appendicitis to bowel incontinence ever mentioned.

Like the other cases in this section, *Saikewicz* is confusing. It may be that the only way to explain the result is to reach a conclusion that the court plainly tried to avoid, namely, that it was right to not treat Saikewicz because his life was not worth living. This conclusion and the immense difficulties it raises become more evident in the Massachusetts cases that have appeared in the aftermath of *Saikewicz*.

In *In re Dinnerstein*,[139] the Massachusetts Supreme Court

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138. *Id.* Moreover, the court explicitly stated that the decision to withdraw or withhold treatment from an incompetent patient like Saikewicz was one that must be made by the courts, not family members or physicians:

> We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a "gratuitous encroachment" on the domain of medical expertise. Rather, 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 the government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent "morality and conscience of our society" no matter how highly motivated or impressively constituted.

*Id.* at 759, 370 N.E.2d at 435. This requirement has been severely criticized by physicians who consider it an egregious intrusion into their professional practice. The court also ignored the clinical realities that make recourse to the courts impossible in many circumstances. It also assumes that courts are capable of making these frank quality-of-life judgments when, in fact, they have no more expertise than the average physician.

139. 6 Mass. App. 466, 380 N.E.2d 134 (1978). It is important to note that the court

held that a sixty-seven year-old woman need not be resuscitated in the situation presented. Shirley Dinnerstein was suffering from Alzheimer's disease, a progressive degeneration of the neuromuscular system that leads by stages from disorientation to dementia and frequently to death. At the time of trial she was permanently comatose. The court was thus faced with a situation in which the patient was terminally ill, and it wisely concluded that the dying process need not be senselessly prolonged by the use of artificial resuscitation measures.

However, the factual limitations present in *Dinnerstein* were not present in *In re Spring*,[140] and confusion resulted. In *Spring* the family of an eighty-seven year-old man who was suffering from chronic organic brain syndrome and end stage renal disease sought permission to refuse continued dialysis for the patient. The Massachusetts Supreme Court held for the family, but in so doing steadfastly refused to offer any clear or principled resolution of the issues pressed upon it by the parties and amici.

The court had no clear, competently expressed statement of the patient's wishes to guide it. The nearest thing to such a statement, evidence that the patient desired to stay on dialysis before he became incompetent, clearly cut against the court's decision.[141] Nevertheless, the court concluded that the belief of Spring's wife as to what he would want must be accorded great weight.[142] The court, however, still seemed confused about the crucial question of whether the proposed treatments represented a chance to save a life or merely an opportunity to prolong an already inevitable dying process.

> In the present case, as in the Saikewicz case, there was no dispute as to the patient's lack of competence. In each case the patient was clearly alive and conscious, and suffering from an incurably fatal disease. The treatments in question were intrusive and were life-prolonging rather than life-saving; there was no prospect of cure, or even of recovery of competence. In the Saikewicz case the life-prolonging treatment had not yet begun, and there was urgency with regard to taking action to be-

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did not require that a court order would have to be secured in the future (as *Saikewicz* seemed to require). Rather, it issued a standing order to cover all future situations in which life-saving therapy might be needed.

140. ___ Mass. ___, 405 N.E.2d 115 (1980).

141. *Id.* at ___, 405 N.E.2d at 118.

142. *Id.*

> gin treatment; in the present case the temporary continuation of a treatment did not greatly change the situation.[143]

This statement is confusing. It is irrelevant that there was no prospect of a cure. Patients with pacemakers are not cured, but their lives are indefinitely prolonged, and they usually do not die of the disease for which the pacemaker was inserted. If the intrusiveness of the therapy is central, then, at a minimum, the court ought to have spelled out what it meant by the use of this term, for the use of such a term to cover the situations of both Saikewicz and Spring is prima facie inconsistent. The real crux of the decision may be that Spring, like Saikewicz, had lost his mental faculties to so great an extent that it was reasonable to refuse further therapy. But the court gave no guidance on this matter of crucial importance. Its confusion belies its expressed confidence in the judiciary's ability to offer persuasive, coherent resolutions to issues of this sort.[144]

The problems just noted are not, however, the central difficulty of *Spring*. The main problem is the court's refusal to offer any post-*Saikewicz* guidance as to when court approval of the removal of life support systems will be necessary. At a minimum the resolution of these cases ought to provide some locus of authority for making the requisite decisions about the withdrawal of treatment. In *Saikewicz* the court seemed to require judicial review of every such case.[145] In *Spring* the court retreated from (i.e., "clarified"[146]) its position. Citing *Dinnerstein* with approval, the court stated that it is not necessary to receive a judicial imprimatur for an order not to resuscitate or treat. The court pointed out that it has never decided the legality of or the penalties attached to action taken in the absence of such an order.[147] A court must surely be given the opportunity to clarify its position, but when it chooses to do so, it ought to be clear. *Spring* in this respect was a complete failure; and the court nearly admitted as much:

> We are not called upon to decide what combination of circumstances makes prior court approval necessary or desirable, even on the facts of the case before us. Moreover, since the scientific

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143. *Id.* at ___, 405 N.E.2d at 120.
144. *Id.*
145. *Saikewicz*, 373 Mass. at 759, 370 N.E.2d at 435.
146. *Spring*, ___ Mass. at ___, 405 N.E.2d at 121-22.
147. *Id.* at ___, 405 N.E.2d at 121.

> underpinnings of medical practice and opinion are in a constant state of development, our opinion as to a particular set of facts may not be a reliable guide to the proper solution of a future medical problem.[148]

This, of course, tells us nothing. The court might as well say that one can do as one pleases in these cases, but that, not knowing where the law lies, one subjects oneself to liability if one oversteps the invisible line. How such a result is to be squared with the bare requisites of a legal system, let alone with the principles of common-law adjudication, is hard to know.

The confusion in *Spring* seemed even greater when *Spring* was compared to the court's earlier decision in *Commissioner of Correction v. Myers*.[149] In *Myers*, a state prisoner was forced to undergo dialysis. The court characterized the required therapy much differently than it had in *Spring:*

> [The trial] court found that dialysis was "relatively painless." . . . Although the treatment was frequently accompanied by such side effects as nausea, headaches, and physical exhaustion, the headaches and nausea . . . would occur even in the absence of treatment. The court also found that the defendant would be able to live an otherwise normal and healthy life if he continued to undergo dialysis.[150]

Despite this, the court, citing *Lane v. Canduria*,[151] held that in normal circumstances Myers probably would have had the right to refuse treatment. However, Myers was in state custody and was attempting to manipulate state officials into acceding to his wish to be placed in a minimum security facility. Given these features, the court held that the state's interest in prison discipline should be given priority. Hence, the court ruled that the patient-prisoner could be compelled to continue to undergo the dialysis treatment which he had already been receiving for a year.

Only one Massachusetts case deals directly with the situation of a patient who is herself refusing clearly life-saving therapy. In *Lane v. Canduria*[152] the daughter of a seventy-seven year-old woman sought to be appointed as her mother's guard-

148. *Id.*
149. ___ Mass. ___, 399 N.E.2d 452 (1979).
150. *Id.* at ___, 399 N.E.2d at 454.
151. 6 Mass. App. 377, 376 N.E.2d 1232 (1978).
152. *Id.*

ian, with power to compel her mother to undergo a life-saving amputation of her leg. There was little doubt that the operation would be life-saving; except for her gangrenous leg, the woman was in no danger of dying.[153]

Seemingly at issue was Mrs. Canduria's competence to decide the matter for herself. Accordingly, the court held for the mother, permitting her to choose death over life. But in so doing the court avoided the issue that simply cannot be avoided in such a case—the right of an individual to terminate her life when she feels it is not worth living. Consider the description given of Mrs. Canduria's decision:

> She has discussed with some persons the reasons for her decision: that she has been unhappy since the death of her husband; that she does not wish to be a burden to her children; that she does not believe that the operation will cure her; that she does not wish to live as an invalid or in a nursing home; and that she does not fear death but welcomes it. She is discouraged by the failure of the earlier operations to arrest the advance of the gangrene. She tends to be stubborn and somewhat irascible. In her own testimony before the judge she expressed a desire to get well but indicated that she was resigned to death and was adamantly against the operation.[154]

Mrs. Canduria plainly found life at her age and in her condition to be less attractive than death, and the court itself opines that it is this very prospect of a nonambulatory existence that renders her choice for certain death "readily understandable." The truth is that Mrs. Canduria's decision was no different from that made by a suicidal individual. She had decided that life in a certain condition was not worth living. There simply is no clear or coherent difference between this choice and that of the suicidal person. They both clearly intend their own death, and both have the means to achieve this goal if permitted to do so.

The assertion by courts and commentators that this is not suicide is woefully unpersuasive. If Mrs. Canduria, having undergone the operation, had then found a nonambulatory existence distressing and had then proposed to poison herself or to stop eating, the state's right to intervene would be plain, and that right is not challenged by the court in *Canduria*. The minor

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153. *Id.* at 378, 376 N.E.2d at 1233.
154. *Id.* at 379, 376 N.E.2d at 1234.

differences between the two situations should not obscure their deep and fundamental similarities. Until the court comes to grips with these similarities, its rationale for resolving such cases will remain unpersuasive.[155]

### 3. *Case Law in Florida*

The Florida case of *Satz v. Perlmutter*[156] is the shortest and simplest of the cases in this section. Perlmutter was a seventy-three year-old man afflicted with amyothrophic lateral sclerosis (Lou Gehrig's disease). This is a motor system disease involving progressive degeneration of muscle and motor ability. From the time of first diagnosis, the life span of the victim is usually two to five years. Eventually, the patient cannot sustain his own respiration and requires mechanical assistance to breathe. The patient's duration on a respirator may last as long as two years.[157]

Unlike any of the patients in the other cases in this section, Mr. Perlmutter was clearly not incompetent. The disease, even in its final stages, produces no dementia or other brain dysfunction that might be associated with loss of competency. Thus, Mr. Perlmutter faced an indefinite but fairly lengthy period of time on a respirator, a time during which he would remain completely lucid and aware of his fate. His family concurred in his decision to remove the respirator, whereupon he sought legal authorization to do so. The state appealed the trial court's decision in favor of Perlmutter, and both the district and state supreme courts agreed that Perlmutter could remove himself from the respirator.[158]

On appeal, the state first claimed that it had a duty to protect life and that what Perlmutter proposed to do constituted either homicide or suicide under Florida law. This claim was dismissed by the district court.[159] The district court wisely distinguished the state's interest in preserving life and preventing suicide from the state's interest in this case, noting that in the present case the life in question could not be preserved.[160] Perlmutter was dying and nothing could be done to alter that fact.

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155. For one such assertion with no argument offered to support it, see R. VEATCH, *supra* note 14, at 115.

156. 362 So. 2d 160 (Fla. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

157. P. BEESON, CECIL'S TEXTBOOK OF MEDICINE 765-66 (1979).

158. 362 So. 2d 160 (Fla. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

159. *Id.* at 162.

160. *Id.*

Thus, his situation was crucially different from that of the patients in *Quinlan* or *Saikewicz*. All that could be done for Perlmutter was to prolong his dying process; his death from this disease could not be prevented. Therefore, since the district court found that the state's interest in preserving life and preventing suicide could not be met no matter what Perlmutter did, it concluded that these state interests could not determine what Perlmutter could legally do.[161]

By distinguishing the situation in *Perlmutter* from those in which the patient is not terminally ill, the court was able to avoid any consideration of the type of life Perlmutter would lead. It thus avoided the need to involve itself in the confusion and subjectivity that surround any judgment concerning the quality of life. Nevertheless, the court did indicate its willingness to uphold the right of any patient to refuse any medical treatment, a position that does raise quality-of-life issues. The court did not, however, indicate how it might resolve these broader issues when they arose.

As it stands, the *Perlmutter* decision is limited to the facts of that case. It offers no broad policy guidelines to lower courts or medical personnel. The court expressly sought guidance from the legislature on these matters, and in contrast to the court in *In re Application of Eichner*[162] discussed below,[163] did not presume the legislature's incompetency or unwillingness to act. In this respect, *Perlmutter* is a well-wrought example of judicial restraint. Further, the distinction drawn in *Perlmutter* between the situation in that case and the typical suicide situation is of crucial importance. What the court failed to notice, however, is that for an otherwise healthy individual a decision to refuse plainly life-saving treatment is prima facie much more similar to suicide than it is to the situation in *Perlmutter*. The court's suggestions that it would look favorably on the right of a healthy individual to refuse life-saving treatment clearly pose enormous questions with respect to the law of suicide and consensual homicide.

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161. *Id.* at 163.

162. 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. 1979), *aff'd sub nom.* Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980).

163. *See infra* text accompanying notes 172-78.

*4. Case Law in New York*

The most detailed decisions with respect to the right to die are those from New York. In *In re Application of Eichner,*[164] the patient, Brother Fox, was an eighty-three-year-old member of the petitioner's religious order. In accordance with Brother Fox's previously expressed wishes, petitioner sought appointment as guardian with power to have a respirator removed from Fox. Fox had suffered massive brain damage following cardiac arrest during surgery. He remained in a state similar to that of Karen Quinlan. Evidence presented at trial suggested that Fox had discussed the *Quinlan* case with Father Eichner and had said that were he in the same situation as Karen Quinlan he would want all artificial life supports removed. The court could have disposed of the case quickly by deferring to other court cases and appointing Eichner as guardian with the requested powers. Indeed, this might have been expected because Fox had made his own choice known and the sincerity and competency of his choice, when made, were uncontested. The court, however, did not choose to take the easy route. It produced a lengthy, complex, and confusing decision.

The trial court properly dismissed the contention, borrowed from *Quinlan* and *Saikewicz,* that the constitutional right of privacy was involved.[165] First, the court held that at a minimum the invocation of this right, deduced partially from the fourteenth amendment's concept of personal liberty, required a showing of some state action. The plaintiff did not attempt to show any state action and the court accordingly found none. This finding was hardly sound, and it was rejected by the appeals court,[166] which noted that it was the hospital's fear of legal repercussions from the state that made it reluctant to accede to Father Eichner's request. Were the trial court's views on this crucial point accepted, a number of cases could be easily dismissed, but only at the cost of abusing constitutional rights.

However, the trial court was on much solider ground when it noted the ambiguities inherent in the concept of privacy and the inappropriateness of using that concept in resolving a case like *Eichner.*

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164. 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. 1979), *aff'd sub nom.* Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980).

165. *Id.* at 460-61, 43 N.Y.S.2d at 590-91.

166. Eichner v. Dillon, 73 A.D.2d at 460-61, 426 N.Y.S.2d at 540.

> The resolution of the awesome question posed by this case, literally one of life and death for Brother Fox, may hereafter profoundly affect all citizens of this State. No one can foresee the nature of future petitions seeking to apply the conclusion reached here. This consideration also underlines this Court's determination not to base a conclusion on the claim of a right of privacy that is insufficiently defined but nevertheless so attractively worded as to invite unrestrained applications made in its name.[167]

Because it held that the right of privacy was not involved, the trial court turned to the common-law tort and contract principle of self-determination. The court reasoned that the right of self-determination, which included the right to refuse medical care, could be overridden only if special justifications were present. The court specifically noted three such justifications: (1) the state's interest in protecting minor children from abandonment and trauma, (2) the state's interest in giving proper respect to the physicians' need to discharge their ethical obligations, and (3) the state's interest in preserving human life.[168] In *Eichner* only the third justification was at issue. However, the trial and appellate courts were confused in their efforts to resolve this issue, and in their confusion they slid into treacherous waters. At the outset, the trial court acknowledged that there was a distinction between those cases in which life could be saved and those in which it could not. It did so in an effort to avoid the fundamental issue of the state's right to intervene to preserve life.[169] Unfortunately, the factual situation in *Eichner* did not submit itself to this analysis. Fox was not dead, and he was not dying. He was like Quinlan, in a permanent vegetative state with no realistic hope of regaining cognitive function. If he were actually dying, the court's position would be tenable. But he was not. As the court tacitly acknowledged, he was in a hopeless condition with respect to his mental faculties, but not with respect to his physical life.[170] If Fox were left on the machine there was no reason, in terms of his pathophysiology, why he could not live for a long period of time (although Fox's age and consequent

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167. 102 Misc. 2d at 199-200, 423 N.Y.S.2d at 591.

168. *Id.* at 203, 423 N.Y.S.2d at 591-92.

169. *Id.* at 203-04, 423 N.Y.S.2d at 593.

170. The court noted that Brother Fox was afflicted "[w]ith irreversible brain damage which has destroyed all of the higher functions of the mind and which has left him suspended in a purely vegetative condition." *Id.* at 203, 423 N.Y.S.2d at 593.

weakened condition made this less likely than in the case of Quinlan).

The partially hidden truth is that the only way either court could reach its decision in *Eichner* was to conclude that while Brother Fox's condition was not medically hopeless, his life was not worth living. The appeals court rejected by implication the claim that Fox had the right to reject therapy in any circumstances in which his life was at stake.[171] Therefore, the appeals court had to find that, in its opinion, Fox should not live anymore, regardless of whether he was terminally ill. Unfortunately, the court was not willing to confront this issue squarely. By refusing to do so, the court refused to give any guidance as to the nature of the worthless life or the degree of disability necessary to absolve the state of its duty to preserve life.

On issues of substance, the *Eichner* court was as weak as the *Quinlan* court, perhaps more deplorably so, since the trial court recognized crucial distinctions and considerations that escaped notice in *Quinlan.* However, the *Eichner* appellate court did say some useful things, mixed with much that is dubious, on matters of law and procedure. First, the appellate court recognized that a clear, firm statement from the individual indicating the kind of care he wants will be present in only a very few cases. It was present in *Eichner,* and for the appellate court that was determinative. The court's recognition that *Eichner* was a special case is certainly correct. However, the court concluded that it had to offer some guidance for the resolution of future, more common cases in which such statements were not present, especially since the legislative branch was unlikely to offer any guidance very quickly.[172]

Once having decided that it should assume these legislative functions, the appellate court was faced with three questions. First, what threshold had to be reached before a decision to withdraw therapy would be permitted? Second, what evidentiary standard had to be met in order to establish the threshold? And finally, where should the locus of authority for making such a decision be placed, once the threshold was reached?

The court was completely confused with respect to the first question.

> The necessary medical criteria for the activation of the pa-

171. 73 A.D.2d at 454-55, 426 N.Y.S.2d at 536.
172. *Id.* at 473, 426 N.Y.S.2d at 548.

> tient's right are self-apparent: he must be terminally ill; he must be in a vegetative coma characterized by the physician as "permanent," "chronic," or "irreversible"; he must lack cognitive brain function; and the probability of his ever regaining cognitive brain function must be extremely remote. The State's interest in protecting the sanctity of life will tolerate no less stringent medical standard than this.[173]

In practical terms this standard is hardly intelligible. Does the court mean that the patient must be comatose, terminally ill, or "brain dead"? These standards are not the same. Presumably, the court did not intend to refer to brain death standards, but if not, what does the term "cognitive brain function" mean? The court offered absolutely no guidance on this point, retreating like the authors of the professional literature to vague generalities about human functioning and the meaning of life, issues with which the court has no expertise. The main problem is that the court's standard is not one standard. It is three standards, only one of which, the terminally ill standard, meets the court's own goal of "strict medical criteria." The cognitive brain function standard is astonishingly vague, and it offers no clinically relevant guidance. The other difficulties of using such an approach have been discussed earlier.[174] Adding the notion of a "comatose" patient may seem to give more guidance, but only at the price of a coherent viewpoint. If the court is, as it says, concerned that the incompetent enjoy the same rights as the competent, then this addition will not do. The class of permanently incompetent persons is far larger than the class of permanently comatose persons. Therefore, those who apply the standard must either arbitrarily limit application of the threshold to only comatose persons, or conclude that profoundly retarded and chronically insane persons have no health, and in the true sense, no life for the state to protect, a view as disturbing as it is false.

One alternative for those who apply the court's standard would be to limit it to terminal patients, as the trial court in *Eichner* wished to do. This would offer a reasonably precise medical threshold, thus avoiding the problems just noted. The appellate court, however, refused to do this because it wanted to help Brother Fox. Thus, the appellate court's reasoning collapses into a bold assertion that it "knows" that Fox's life is worthless

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173. *Id.* at 468, 426 N.Y.S.2d at 545.

174. *See supra* text accompanying notes 61-65.

and therefore beyond the care of the state[175]—a proposition unsupported by any rationale.

The appellate court did better with the second of its three questions—the evidentiary standard required. It wisely eschewed the loose "preponderance" standard in favor of the tighter "clear and convincing" standard typically used when significant interests are at stake.[176]

The third question facing the court concerned the procedural methods for making the decision to remove therapy. The appellate court dealt with this issue in two ways. In the instant case the court appointed Eichner as Fox's guardian and gave him the authority to have the therapy removed. However, the court recognized the existence of numerous other terminally ill and comatose patients. Having already concluded that the legislature was unlikely to act on this issue in the near future, the court took upon itself clearly legislative powers and enacted a lengthy and detailed procedure for resolving such cases:

> Accordingly, we hold that the following procedure shall be applicable to the proposed withdrawal of extraordinary life-sustaining measures from the terminally ill and comatose patient. The physicians attending the patient must first certify that he is terminally ill and in an irreversible, permanent or chronic vegetative coma, and that the prospects of his regaining cognitive brain function are extremely remote. Thereafter, the person to whom such certification is made, whether a member of the patient's family, someone having a close personal relationship with him, or an official of the hospital itself, may present the prognosis to an appropriate hospital committee. If the hospital has a standing committee for such purposes, composed of at least three physicians, then that committee shall either confirm or reject the prognosis. If the hospital has no such standing committee, then, upon the petition of the person seeking relief, the hospital's chief administrative officer shall appoint such a committee consisting of no fewer than three physicians with specialties relevant to the patient's case. Confirmation of the prognosis shall be by a majority of the members of the committee, although lack of unanimity may later be considered by the court.
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> Upon confirmation of the prognosis, the person who secured it may commence a proceeding pursuant to Article 78 of the Mental Hygiene Law for appointment as the Committee of

175. 73 A.D.2d at 465, 426 N.Y.S.2d at 543.
176. *Id.* at 468-69, 426 N.Y.S.2d at 545.

> the incompetent, and for permission to have the life-sustaining measures withdrawn. The Attorney-General and the appropriate District Attorney shall be given notice of the proceeding and, if they deem it necessary, shall be afforded an opportunity to have examinations conducted by physicians of their own choosing. Additionally, a guardian ad litem shall be appointed to assure that the interests of the patient are indeed protected by a neutral and detached party wholly free of self-interest.[177]

On final appeal the state's highest court upheld Father Eichner's petition, but reversed the appeals court's elaborate review scheme.[178] In upholding the petition, the court focused exclusively on the common-law basis of Brother Fox's right to refuse treatment, explicitly rejecting the privacy basis. Secondly, it reached its result by holding that Brother Fox's previously expressed wishes were determinative.

With respect to the common-law basis for its decision, the court ignored the fundamental issue of the right of a person to choose death over life. The relevant passage in the decision reads

> The State has a legitimate interest in protecting the lives of its citizens. It may require that they submit to medical procedures in order to eliminate a health threat to the community. . . . It may, by statute prohibit them from engaging in specified activities, including medical procedures that are inherently hazardous to their lives. . . . In this State, however, there is no statute which prohibits a patient from declining necessary medical treatment or a doctor from honoring the patient's decision. To the extent that existing statutory and decisional law manifests the State's interest on this subject, they consistently support the right of the competent adult to make his own decision by imposing civil liability on those who perform medical treatment without consent, although the treatment may be beneficial or even necessary to preserve the patient's life . . . . The current law identifies the patient's right to determine the course of his own medical treatment as paramount to what might otherwise be the doctor's obligation to provide needed medical care.[179]

This is a woefully inadequate analysis. The liability of the physician was not at issue in *Eichner,* nor was the right to reject ordi-

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177. *Id.* at 476-77, 426 N.Y.S.2d at 550 (citations omitted).
178. *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).
179. *Id.* at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273 (citations omitted).

nary medical care a very apt analogy. The central issue was the right of a person to act in a manner that is certain to cause his death. The court admitted that the state may prohibit a person from engaging in life-threatening medical care. Nonetheless, the court did not pursue this analogy to the more applicable state right to intervene against suicidal behavior. Unfortunately, the most fundamental questions raised by this line of analysis were not broached by the court.

The deficiencies of the second part of the court's holding—the part relying on Fox's expressed wishes—stem directly from its erroneous reliance on the common-law right to refuse treatment. By taking refuge in Brother Fox's previously expressed wishes, the court sought to disengage itself from any speculation concerning what Fox might have wanted and from the danger of letting third parties make such an awesome judgment. Still, in so doing the court plainly raised the issue of Brother Fox's right to choose death over life.[180] The court provided no analysis on this issue, aside from a completely irrelevant reference to Justice Cardozo's famous dictum about the right of patients.[181] If there is a right to choose death over life, the court never revealed why or how it came to be enumerated among the principles of the common or constitutional law.

### 5. *Case Law in Delaware*

The most recent state court decision discussed in this section is *Severns v. Wilmington Medical Center*,[182] a case from Delaware. Given the precedents, the arguments and outcome of the case were predictable. The facts were simple. The fifty-five year-old woman was left permanently comatose following an automobile accident. Two specialists rated her chances of recovery to full adult sapience as zero and one in ten thousand respectively. At the time of trial she required a respirator to clear out her lungs and prevent infection.

Her husband petitioned the chancery court for an order permitting the withholding of the respirator, antibiotic drugs, and a tracheotomy tube. He also sought an order not to resuscitate her if it became necessary to do so. The chancery court certified a series of questions regarding its powers in the matter to the

180. *Id.* at 376-77, 420 N.E.2d at 70, 438 N.Y.S.2d at 272.
181. *Id.*
182. 421 A.2d 1334 (Del. 1980).

state supreme court. The state supreme court held that one of the questions was dispositive: " '[I]n order for the court of chancery to grant the relief sought, must there be legislation authorizing and providing guidelines for the relief sought?' "[183]

The state supreme court divided the question into two parts: (1) the appointment of a guardian and (2) his powers. The first question was simple. The chancery court clearly had the power to appoint Mr. Severns as guardian for his obviously incompetent wife.[184] The second issue was somewhat more complicated. The court rejected the contention of Severns and the medical center that applicable state guardianship statutes authorized the chancery court to set the terms of guardianship so as to grant the authority sought.[185] Nonetheless, it granted Mr. Severns that authority, at the same time imploring the legislature for guidance in future cases.[186]

The whole rationale for the court's decision was its two sentence assertion that Severns' wife had "a constitutional right to accept or reject medical assistance"[187] and that accordingly, even in the absence of a statute, a chancery court can act to ensure that a guardian exercise this right. The court simply adopted this constitutional right from the cases already examined. However, such a right has yet to be defined with any precision, nor has its place in the constitutional spectrum been compellingly demonstrated, especially when the true choice is for death over life.

The court's failure to conduct such an analysis is rendered more striking by its own acknowledgement that "[w]ith [the] single exception—which involves conduct so evil that the ultimate penalty (death) is imposed—our society has sustained life, and our medical techniques and our laws have been applied to preserve it."[188] If this assertion is valid, the court's decision is difficult to sustain. Why should a third party be permitted to choose death over life for an incompetent person? The court gives no reply except the weak assertion about the right to refuse therapy noted above.[189]

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183. *Id.* at 1340.
184. *Id.*
185. *Id.* at 1346-47.
186. *Id.* at 1347.
187. *Id.* at 1348.
188. *Id.*
189. *See supra* text accompanying note 186.

The case for a creative, activist judiciary has been made with renewed vigor in the last two decades. From tort law to constitutional jurisprudence it has been argued that judicial inventiveness has enabled our legal system to keep pace with changes in public mores, rapid technological advances and the rise of new and powerful institutions and interests. Whether a case for judicial activism can be made in any or all of these areas remains an open question. But in the cases under review here, judicial creativity has turned out to be a failure on any but the narrowest of case-specific grounds. In a democratic regime the judiciary can only justify its counter-majoritarian activism by the quality of the arguments it gives for its holdings and the soberness of the results it achieves when viewed from the broadest possible policy perspective. On these counts the appellate decisions in the above cases are failures. Relying on often inapplicable concepts like privacy, ignoring or misstating crucial medical facts and distinctions among cases, failing completely in most cases to wrestle with the profoundest question of whether there is life that does not merit the most minimal social protections imaginable, these courts have retreated to noble phrases and conventional platitudes. Wishing to avoid the awesome responsibility of deciding for death, they have tried to transfer that responsibility to the incompetent patient, purporting to discover what he or she would want, when in fact they have no basis for making such a decision. They have claimed, obliquely, that the patient's condition is "worthless," yet they have offered no definition of "worthlessness." The courts' efforts to give legal recognition to the right to die have led them to make decisions based on vague and arbitrary assertions that some lives are not worth living. Further, their failure to provide adequate guidance for future cases perpetuates the likelihood that such assertions will continue to be the basis for future decisions in these situations. Again, one must wonder how a liberal regime such as ours can sanction such vague and arbitrary decisions with respect to matters as fundamental as human life.

## V. Statutory Reform: Enactments and Proposals

None of the currently existing statutes, and only a few of the legislative proposals, go as far as authorizing active euthanasia. Most are concerned with the patient's right to refuse life-prolonging treatment. Still, they are often confusing, sometimes poorly drafted, and generally very moderate in scope. Before ex-

amining the various state legislative proposals, it will be helpful to review carefully the existing statutes.

### *A. Existing Statutes*

To date, ten states have enacted a euthanasia statute of some sort. All ten statutes give legal effect to a written document in which a person states that under certain conditions he wants no more life-prolonging therapy.[190] However, the manner in which the document is given legal force varies in many crucial details from jurisdiction to jurisdiction. These differences include (1) the threshold standard a patient must meet before treatment may be withdrawn, (2) the effect of proxy consent by a family for one of its members, (3) the form the document must take, (4) the context in which the declaration must or may be honored, (5) the length of time a declaration remains in effect, (6) the sanctions provided for falsifying a document or for failure to comply with its terms, and (7) various miscellaneous provisions. Each of these differences will be examined briefly.

#### *1. The Threshold Standard*

Eight of the ten statutes adopt a disease-oriented threshold of applicability. The qualified patient is one whose disease is terminal. That is, unless a physician certifies that the individual is terminally ill, the law has no effect.[191] Whether this actually restricts a broad common-law right to refuse medical care is a disputed matter.[192]

Even in the restricted sphere of terminal illness, however, there are serious differences among the statutes and even contradictions within statutes. Some laws adopt a per se terminal

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190. ARK. STAT. ANN. § 82-3802 (Supp. 1981); CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39.4504 (Supp. 1981); KAN. STAT. ANN. § 65-28,103 (1980); NEV. REV. STAT. § 449.610 (1979); N.M. STAT. ANN. § 24-7-3 (1981); N.C. GEN. STAT. § 90.321 (1981); OR. REV. STAT. § 97.055 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1981).

191. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39.4504 (Supp. 1981); KAN. STAT. ANN. § 65-28,103 (1980); N.M. STAT. ANN. § 24-7-3 (1981); N.C. GEN. STAT. § 90.321 (1981); OR. REV. STAT. § 97.055 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1981).

192. *See* McCormick & Hellegers, *Legislation and the Living Will*, 136 AMERICA 210 (1977). For a review of other criticisms of the living will concept see Horan & Marzen, *Death With Dignity and the Living Will: A Commentary on Recent Developments*, 5 J. LEGIS. 81 (1978).

criterion: The patient must be irreversibly dying.[193] Others, somewhat inconsistently, also include an "immediacy" standard: The patient's death must be imminent, whether or not the proposed treatment is given.[194] Although none of the statutes defines imminency, this standard is quite different from the irreversibly dying standard. Consider the fact situation in *Perlmutter*. While Perlmutter's death as a result of that disease was certain (i.e., he was irreversibly dying), it could hardly be claimed that death was imminent, given the prospect of another year of life on the respirator. Extrapolating a bit, consider a patient first diagnosed with the same disease. The average life span from the time of initial diagnosis is three to five years. Such a patient is terminal, given present knowledge, but hardly in danger of imminent death. Even when the patient needs to be placed on a respirator, he is likely to live eighteen months to two years in that condition. It is difficult to see how this meets any reasonable interpretation of imminency.

One statute, that of Arkansas, adopts an entirely different and much looser standard of applicability, a therapeutic threshold. The Arkansas statute requires that two physicians certify that the refused therapy is "artificial, extraordinary, extreme or radical."[195] This standard is extremely vague. In fact, one might just as well assert that any therapy may be refused in any circumstances. The differences among physicians concerning the definition of extraordinary means of life support are so enormous that little is gained by requiring physician certification that the threshold has been reached.[196] If the statute was designed to offer regulatory guidance to physicians, patients, and hospitals concerning who may and may not refuse life-saving medical care, it has utterly failed to do so.[197]

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193. KAN. STAT. ANN. § 65-28,102 (1980); N.M. STAT. ANN. § 12-7-2 (1981).

194. CAL. HEALTH & SAFETY CODE § 7187 (West Supp. 1981); IDAHO CODE § 39.4503 (Supp. 1981); NEV. REV. STAT. § 499.590.610 (1979); OR. REV. STAT. § 97.050-.055 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 2(3) (Vernon Supp. 1981); WASH. REV. CODE ANN. § 70.122.020 (Supp. 1981).

195. ARK. STAT. ANN. § 82-3802 (Supp. 1981).

196. D. CRANE, *supra* note 63; Skeel & Benson, *supra* note 63.

197. North Carolina's statute seems to confuse the disease and a therapeutic standard. It provides "extraordinary means" of keeping life alive may be withdrawn if the patient is terminal. These "means" are described as "any medical procedure or intervention which in the judgment of the attending physician would serve only to postpone, artificially, the moment of death by sustaining, restoring, or supplanting a vital function." N.C. GEN. STAT. § 90-321(a)(2) (1981). Absent an additional terminality criterion, this definition would apply to insulin for diabetics. Surely that was not what was in-

*2. The Effect of Proxy Consent*

The preceeding standards may or may not apply to decisions rendered for an incompetent patient (either child or adult). Although none of the statutes offers one threshold standard for a decision made by the patient himself and another for a decision made by a guardian, some apply only to the competent adult, while others permit decisions by parents or family members.

Those statutes that are patterned after the pioneering California law specifically restrict themselves to competent adults, adults "of sound mind."[198] Those that are not so restricted offer coverage to different classes of incompetent patients. North Carolina's statute authorizes substituted consent only for an irreversibly comatose person who has not already executed the required document.[199] In that instance, the document may be executed for the individual by (1) a spouse, (2) a legal guardian, or (3) a majority of relatives of the first degree (in that order). When none of the above is possible, the physician may act on his own.[200] The statute makes no reference to other classes of incompetents, leaving out special consideration for children. New Mexico's statute is just the reverse. It provides for proxy consent for minors, but not for incompetent adults.[201] The spouse, parent, or guardian of a minor may execute a document on his behalf. The document must then be certified by a district court, which may in addition hold its own evidentiary hearing.[202] Arkansas fuses both of these classes together. Both minors and incompetent adults are covered by the statute, provided that two physicians certify that the proposed treatment meets the vague "extraordinary" criterion noted above.[203] In that event, any one of a number of relatives may execute the document requesting

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tended. However, if the patient is terminal, it is difficult to see why his dying should be prolonged by ordinary but not extraordinary means, something the statute clearly implies.

198. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); IDAHO CODE § 39.4504 (Supp. 1981); KAN. STAT. ANN. § 65-28,103 (1980); NEV. REV. STAT. § 449.610 (1979); OR. REV. STAT. § 97.055 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1981).

199. N.C. GEN. STAT. § 90.322 (1981).

200. *Id.*

201. N.M. STAT. ANN. § 24-7-4 (1981).

202. *Id.*

203. ARK. STAT. ANN. § 82-3803 (Supp. 1981).

discontinuance of the treatment.[204]

The Arkansas and North Carolina statutes suffer from a serious defect. They lack adequate safeguards to ensure that those entrusted with the decision are in fact acting in the patient's best interests. The mere fact that the decision maker has a marital or blood relationship with the patient does not ensure such a decision. Moreover, both statutes contemplate a divided opinion among the relatives of the first degree, as evidenced by the grant of power to decide to a bare majority of them. This portrays a dubious picture of family harmony. But if such a picture is largely fictitious, why entrust such a momentous decision to the unscrutinized feelings and biases of the family?

Of course, it can be argued that the type of court scrutiny envisioned in the New Mexico statute is both an impossible burden on the courts and an unwise intrusion in a private matter. The intrusiveness argument fails readily. If the situation is grave enough, the mere fact that it is usually a private transaction will not shield it from legal scrutiny. The impossibility argument is sounder. It is true that the complexities of clinical medicine and the ever-changing medical status of individual patients would make court review of every case, even every case involving incompetent persons, a very difficult task. Nevertheless, the problem that court review is designed to solve remains unresolved in those laws that seek to transfer to third parties the unregulated power to chose death over life for an individual. Failure to resolve this problem constitutes a serious defect in those laws. This is especially true with respect to the Arkansas statute with its hopelessly vague threshold standard. Almost any patient can meet the threshold. Establishing the contrary in a civil or criminal action would be substantially more difficult than showing that a patient was not in fact terminal (as would be required by every other statute).[205] Allowing third parties to bring about a nondying individual's death in such circumstances is an open invitation to abuse and unfairness.

### 3. *The Form of the Document*

The form of the document authorizing the removal or withholding of life-prolonging therapy is also different in the various

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204. *Id.*

205. This point is made in another context in G. GRISEZ & J. BOYLE, *supra* note 14, at 131-33.

statutes. The statutes in Arkansas and New Mexico provide that the form used in executing wills is to be used.[206] This promotes economy in statutory drafting, but it ignores the extensive differences between the two situations. The nature of these differences may be highlighted by considering the extensive forms prescribed by most other statutes. Typically, the other statutes require that the form include (1) a provision stating that the individual knows he is terminal,[207] (2) a declaration that he has been told this by a physician named in the document, (3) a statement concerning the nature of the treatment to be withheld, (4) a provision setting forth the duration of effect of the document, and (5) a clause describing the means of revocation.[208]

These various provisions illuminate the differences between those situations in which the right to refuse treatment is asserted and those in which the typical will is drafted. It is possible to make a cogent argument that given the complexities of each patient's medical situation, the presence of a set form is an unwise and unneeded encumbrance. If a set form is provided, however, it ought to be drafted with close attention to the circumstances in which it will be used, rather than merely copied from substantially dissimilar areas of the law.

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206. ARK. STAT. ANN. § 82-3802 (Supp. 1981); N.M. STAT. ANN. § 24-7-3 (1981).

207. This provision cannot be filled out prior to the onset of the terminal illness. However, most statutes that require that the declaration contain such a provision permit a more general hypothetical statement that can be assented to by a healthy person.

208. The Idaho form is typical:

> I,_____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artifically prolonged under the circumstances below:
>
> 1. In the absence of my ability to give directions regarding the use of artificial life-sustaining procedures as a result of the disease processes of my terminal condition, it is my intention that such artificial life-sustaining procedures should not be used when they would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent whether or not the artificial life-sustaining measures are utilized.
>
> 2. I have been diagnosed and notified that I have a terminal condition known as_____ by_____, M.D., whose address is_____ and whose telephone number is_____.
>
> 3. This directive shall have no force or effect after five years from the date filled in above.
>
> 4. I understand the full impact of this directive and I am emotionally and mentally competent to make this directive.

IDAHO CODE § 39.4504 (Supp. 1981).

*4. The Conditions Under Which the Document Must or May Be Honored*

The differences noted in the form of the written declaration reflect profound differences in the conditions under which the document may or must be honored. Some of the statutes do not state when or even if the declaration must be obeyed by the attending physician.[209] Presumably, under general principles of tort and contract law the declaration must be honored in those situations in which it applies, even if it carries no express stipulation to this effect. Some of the statutes state this directly—the document must be respected as the last competently expressed statement of the patient's wishes and, therefore, its terms must be observed.[210] Finally, several states, following California's lead, have adopted a two-tiered approach to determine the respect that must be given the declaration. They allow the individual to execute a document at any time. However, unless those parts stating the name of the terminal illness and the physician who made the diagnosis are filled in, the document is presumed to have been executed before the patient had a terminal illness. In that event, the attending physician may give weight to the declaration, but he is not bound by its terms.[211]

The rationale behind this seemingly incongruous provision is intriguing, but much too neat for the real world of clinical medicine. The justification offered is that the actual onset of terminal illness is a crucial new fact that the healthy individual is not faced with when he signs the document. Before a person can make an informed decision on this matter—the only type of decision worthy of mandatory respect—he must be aware of his actual illness. Where the document is made before knowledge of an actual terminal illness, the argument continues, the declaration should be taken for what it is: a hypothetical statement that should be accorded respect, but not slavishly followed.[212]

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209. ARK. STAT. ANN. § 82-3801 (Supp. 1981); IDAHO CODE § 39-4502 (Supp. 1981); N.M. STAT. ANN. § 24-7-1 (1981); N.C. GEN. STAT. § 90.320 (1981).

210. CAL. HEALTH & SAFETY CODE § 7191 (West Supp. 1981); OR. REV. STAT. § 97-075 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 7 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.060 (Supp. 1981).

211. CAL. HEALTH & SAFETY CODE § 7191 (West Supp. 1981). Other states adopting this provision are Oregon and Texas. OR. REV. STAT. § 97.055 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 7 (Vernon Supp. 1982).

212. Address by State Senator Barry Keene, *The Natural Death Act: A Well Baby Check up on its First Birthday*, Speech at the N.Y. Academy of Sciences, Conference of Brain Death, Nov. 1977, *reprinted in* 315 ANNALS OF N.Y. ACAD. OF SCI. Senator Keene

In the abstract this sounds reasonable. Nevertheless, it is insensitive to the large number of patients, particularly the elderly, whose "terminal diagnosis" comes only after a lengthy series of pathological conditions has left them in a condition of severely reduced competency.[213] Furthermore, many patients will not inform the hospital or its personnel of the existence of such a document until after therapy, with its attendant restrictions on the patient's ability to communicate, has been started. In such situations it seems unreasonable to refuse to adhere to a competently signed declaration stating clearly that in certain conditions treatment is to be withheld or withdrawn.

### 5. *The Duration of Effectiveness of the Document*

The statutes also differ in the length of time the declaration can remain in effect. Some statutes provide that a declaration will remain in force unless specifically revoked by the individual.[214] Others, again following the California statute, provide that the document must be re-executed every five years.[215] The later provisions give the patient an opportunity to review this momentous decision at regular intervals. For this reason, the California procedure is preferable, especially since it does not inhibit the exercise of the rights in question.

### 6. *The Sanctions for Falsifying or Failing to Comply with a Declaration*

The statutory sanctions for falsifying a declaration or for

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authored the California act.

The Nevada statute seems to make it impossible for a patient to force the physician to obey the terms of the document. The prescribed form specifically states that it is to be regarded as the patient's last competent declaration when he is "in a terminal condition and becomes comatose." Further, the statute specifically provides that the physician "shall give weight to the declaration . . . but the attending physician may also consider other factors in determining whether the circumstances warrant following the directions." NEV. REV. STAT. § 449.640 (1979). This puts the patient in a "Catch-22" situation because the form is consulted only if the patient is comatose; the attending physician is not required to follow it; and the patient, because he is comatose, cannot make his will known.

213. For a discussion of the impediments to competency see Kamisar, *supra* note 5.

214. ARK. STAT. ANN. § 82-3802 (Supp. 1981); KAN. STAT. ANN. § 65-28,104 (1980); NEV. REV. STAT. § 449.620 (1979); N.M. STAT. ANN. § 24-7-6 (1981); N.C. GEN. STAT. § 90.321; TEX. REV. CIV. STAT. ANN. art. 4590h, § 7(b) (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.040 (Supp. 1981).

215. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1981); IDAHO CODE § 39.4504 (Supp. 1981); OR. REV. STAT. 98.055(6) (1979).

failure to comply with its terms vary widely. Three of the ten statutes do not provide any penalties for falsifying a declaration.[216] This is a surprising omission since the existence of a false document could lead to the premature death of an individual, the most serious legal consequence. Generally, the other states provide misdemeanor penalties for defacing or falsifying a document.[217] If someone's death results from such an act, the violator can be tried for murder.[218]

Only three statutes provide any penalties for the physician's failure to comply with or take steps to see that another physician complies with the directive.[219] The penalties themselves are minor—usually a finding of unprofessional conduct.[220] Two statutes provide that a physician must transfer a patient whose declaration he cannot in good conscience honor, but they provide no penalties for failure to do so.[221]

The lack of any penalties in a majority of the bills is a serious oversight. All of the statutes provide civil and criminal immunity for those physicians who act within the terms of the law.[222] To offer such a large degree of immunity in this sensitive area without imposing sanctions to protect the individual's right to have his wishes respected is both onesided and unjustified.

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216. ARK. STAT. ANN. § 82-3801 to -3804 (Supp. 1981); IDAHO CODE § 39.4504 (Supp. 1981); N.C. GEN. STAT. § 90.320-.323 (1981).

217. CAL. HEALTH & SAFETY CODE § 7194 (West Supp. 1981); KAN. STAT. ANN. § 65-28,107 (1980); NEV. REV. STAT. § 449.660 (1979); OR. REV. STAT. § 97.090 (1979); WASH. REV. CODE ANN. § 70.122.090 (Supp. 1981). New Mexico makes falsification of a document a second degree felony. N.M. STAT. ANN. § 24-7-10 (1981).

218. CAL. HEALTH & SAFETY CODE § 7194 (West Supp. 1981); KAN. STAT. ANN. § 65-28,107(c) (1980); TEX. REV. CIV. STAT. ANN. art. 4590h, § 9 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.090 (Supp. 1981).

219. CAL. HEALTH & SAFETY CODE § 7191 (West Supp. 1981); KAN. STAT. ANN. § 65-28,107 (1980); TEX. REV. CIV. STAT. ANN. art. 4590h, § 7 (Vernon Supp. 1982).

220. *Id.*

221. OR. REV. STAT. § 97.070 (1979); WASH. REV. CODE ANN. § 70.122.060 (Supp. 1981).

222. The Kansas statute is typical and reads in part:

> No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration made in accordance with this act shall, as a result thereof, be subject to criminal or civil liability or be found to have committed an act of unprofessional conduct.

KAN. STAT. ANN. § 65-28,106 (1980).

### 7. *Miscellaneous Provisions*

Each of the statutes has miscellaneous provisions. Some statutes provide that the existence or nonexistence of a declaration has no effect on the sale of insurance.[223] Others state flatly that death under the terms of a declaration is not suicide.[224] Several statutes also expressly state that it is not mercy killing.[225] Some provide a pregnancy exception that prohibits the enforcement of a declaration during pregnancy.[226] Finally, some statutes expressly provide that their provisions do not restrict any previously held right to forego medical care.[227]

## *B. Legislative Proposals*

The various state legislative proposals are even more varied and confusing than the statutes already enacted. Some frankly endorse mercy killing,[228] but they are few in number and have little chance of passage. These may be briefly dismissed here by noting that they are so poorly drafted and would entail such radical changes in common-law jurisprudence that they may be safely ignored.

The passive euthanasia bills are more numerous. Since 1975, twenty-seven states other than those that already have living will legislation have considered such legislation.[229] Most of these

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223. CAL. HEALTH & SAFETY CODE § 7192 (West Supp. 1981); IDAHO CODE § 39-4508 (Supp. 1981); KAN. STAT. ANN. § 65-28,108 (1980); NEV. REV. STAT. § 449.650 (1979); N.M. STAT. ANN. § 24-7-8 (1981); N.C. GEN. STAT. § 90.321 (1981); OR. REV. STAT. § 97.080 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 8 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.070 (Supp. 1981).

224. CAL. HEALTH & SAFETY CODE § 7192 (West Supp. 1981); KAN. STAT. ANN. § 65-28,108 (1980); NEV. REV. STAT. § 449.650 (1979); N.M. STAT. ANN. § 24-7-8 (1981); N.C. GEN. STAT. § 90-321 (1981); OR. REV. STAT. § 97.090 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 8 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.070 (Supp. 1981).

225. CAL. HEALTH & SAFETY CODE § 7195 (West Supp. 1981); KAN. STAT. ANN. § 65-28,109 (1980); NEV. REV. STAT. § 449.670 (1979); N.C. GEN. STAT. § 90.320 (1981); OR. REV. STAT. § 97.090 (1979); TEX. REV. CIV. STAT. ANN. art. 4590h, § 10 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.100 (Supp. 1981).

226. CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1981); KAN. STAT. ANN. § 65-28,103 (1980); TEX. REV. CIV. STAT. ANN. art. 4590h, § 3 (Vernon Supp. 1982); WASH. REV. CODE ANN. § 70.122.030 (Supp. 1981).

227. CAL. HEALTH & SAFETY CODE § 7192 (West Supp. 1981); IDAHO CODE § 39-4508 (Supp. 1981); KAN. STAT. ANN. § 65-28,108 (1980); NEV. REV. STAT. § 449.680 (1979); N.M. STAT. ANN. § 24-7-9 (1981); N.C. GEN. STAT. § 90.320 (1981); OR. REV. STAT. § 97.085 (1979).

228. Mont., H.R. 256 (1975); Wis., A. 1207 (1975).

229. Information for this section, including copies of draft legislation, was obtained from the legislative reference services of each state.

proposals are patterned after those already enacted. However, they differ widely among themselves, and some differ greatly from any existing statute. Therefore, they may be usefully reviewed in the same manner as were the existing statutes.[230]

### 1. *The Threshold Standard*

The proposals vary from one another most widely in the threshold standard that must be reached before therapy may be withdrawn. Most bills seem to intend a disease-oriented, "terminality" standard, i.e., the patient must be suffering from a disease that will kill him regardless of what is done medically.[231] Frequently, however, the bills include both a per se terminal standard and an even stricter "immediacy" standard as well.[232] Several bills define a "qualified patient" with an immediacy standard and then in the same or a separate subsection define "terminal patient" in different terms.[233] These are problems that could be remedied fairly easily, but they exist in a surprising number of proposals.

Some bills seem to endorse a disease standard, but then limit the application of the law to patients who are comatose.[234] This approach clearly will not do. If the rationale for the law is to clarify the rights of terminal patients, then restricting its application to such a very minor subclass violates the most mini-

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230. Because most proposals do not contain any provision governing the duration of the effectiveness of the document, the discussion of that consideration is included in the miscellaneous provision section.

231. Ariz., S. 1177, 32d Leg., 2d Sess. (1979); Del., H.R. 570, 130th Leg., (1979); Fla., H.R. 374 (1977); Ind., H.R. 1366 (1977); N.J., G.A. 859 (1980); N.Y., S. 5514, Reg. Sess. (1979).

232. Alaska, H.R., 10th Leg., 2d Sess. (1976); Colo., H.R. 1301, 52d Leg., 1st Sess. (1979); Del., H.R. s, 129th Leg., 1st Sess. (1977); Fla., H.R. 740 (1979); Hawaii, S. 1240 (1979); Iowa, H.R. 2351 (1978); Iowa, S. 2062 (1980); La., H.R. 1240 (1977); Md., S. 60 (1977); Md., S. 388 (1979); Mass., H.R. 3515 (1979); Mass., H.R. 1096 (1980); Mont., S. 75 (1979); N.H., H.R. 300 (1977); Okla., H.R. 1334, 36th Leg., 1st Sess. (1977); S.C., H.R. 2419 (1977).

233. A South Carolina bill typifies this error. In section 3(c) it defines "life-sustaining procedure" as "an intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where . . . death is imminent whether or not such procedures are utilized." In section 3(f) "terminal condition" is defined without reference to imminent death. In section 3(f) a "qualified patient" is defined as one suffering from a terminal illness, yet in the prescribed form (section 4) the death is specified as "imminent." S.C., H.R. 2419 (1977).

234. Ga., H.R. 630 (1977); Okla., H.R. 1334, 36th Leg., 1st Sess. (1977); Utah, H.R. 11, Gen. Sess. (1977).

mal principles of fairness. Even if it is presumed that a competent person can assert his common-law right of refusal and that he therefore does not need statutory assistance, it is still an inadequate provision. The class of incompetent persons is far larger than the class of comatose persons. This is especially true among terminal patients, whose competency is often seriously affected by the use of pain-killing drugs.[235]

One proposal offers looser standards than any yet considered. It provides that life-sustaining care can be withdrawn "if at any time I should suffer a serious physical condition which causes me severe distress or unconsciousness, and my physician, with the concurrence of two other physicians, believes that there is no expectation of my regaining health, and but for the use of life-sustaining mechanisms my death would be imminent."[236] This standard raises fundamental questions about suicide and the meaning of life, as well as statutory problems of defining "severe distress." These problems have all been thoroughly discussed above.[237] Suffice it to say that neither this, nor any similar bill, solves these problems. Thankfully, therefore, this is the only such bill introduced in any state.

Some bills increase the confusion by including a treatment standard with the disease standard. A few of these provide that "extraordinary" procedures may be withheld from a terminal patient, without specifying what these procedures are or whether a special subclass of medical procedures is intended.[238] Statutory specification of such a subset would be hopeless and would pose constitutional problems. If this is not intended, such wording should be revised. Some bills include both standards. An Arizona proposal authorized removal of "heroic or extraordinary measures designed not for the cure or recovery of the patient from the terminal condition from which the patient suffers but

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235. Kamisar, *supra* note 5, at 985-90.

236. Alaska, H.R. 744 § 1, at 1-2, 9th Leg., 2d Sess. (1976).

237. *See supra* text accompanying notes 35-50.

238. Colo., H.R. 1301, 52d Leg., 1st Sess. (1979); Ga., H.R. 630 (1977); Ind., H.R. 1366 (1979); Utah, H.R. 11, Gen. Sess. (1977); Va., H.R. 872 (1980). The Utah and Indiana proposals state that the individual may refuse care that "sustains life" (or similar wording). They also include provisions for declaring the patient terminally ill and therefore a "qualified patient." These provisions are vague in several crucial aspects. A patient like Karen Quinlan would arguably fit under the "sustain life" standard, but not under the terminal illness standard. Respirators and other therapy could keep such a patient alive indefinitely. They would "sustain her life," but not cure her of her illness. Nevertheless, it is medically inaccurate to say that these patients are dying except in the extended sense that all persons will someday die.

rather is supportive treatment designed solely to prevent the death of the patient."[239] If the patient is terminal, nothing will "prevent" his death; it can only be postponed. If the treatment will really prevent death, then the patient is not terminal.

Finally, some proposals eschew any standard. A Missouri proposal simply declares living wills legal in the state, with no other statutory guidance.[240] A Michigan proposal would have given individuals the power to appoint a proxy to make medical decisions for them when they were incompetent. The proxy could have made any decision he or she chose, provided only that the patient was incompetent.[241] Despite the fact that this proposal has received prestigious endorsement,[242] it is really very problematic. Under its terms, quality of life judgments would be legitimated with no guidance on how such judgments should be made. Two patients with exactly the same medical condition would be allowed to live or die depending on their proxies' values or concerns. It is difficult to see how this can be squared with elementary standards of fairness. That such unfairness happens regularly in clinical medicine is true, and perhaps unavoidable, but to endorse it legally is a far different and much more dangerous move.

### 2. *The Effect of Proxy Consent*

Most of the bills deal with the situation of a competent adult patient who can sign a document prior to illness. A few provide for proxy consent, either for incompetent adults or for children.[243] Given the attention focused on the matter by the *Quinlan* case, the paucity of bills that address the issue of proxy consent is quite striking. Those few bills that do provide proxy consent differ widely in specifics. Some follow Arkansas' lead and allow a bare majority of one's children to offer proxy consent in the event that a spouse or parent will not sign or cannot

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239. Ariz., H.R. 2336, 34th Leg., 2d Sess. (1977).

240. Mo., S. 537, 80th Leg., 2d Sess. (1979).

241. Mich., H.R. 5778 (1977). This bill was reintroduced in 1979 as Mich., H.R. 4058 (1979).

242. Dr. Arnold Relman, editor of the prestigious NEW ENGLAND JOURNAL OF MEDICINE has endorsed it. *See* Relman, *Michigan's Sensible Living Will*, 300 N.E. J. MED. 1270 (1979).

243. Colo., H.R. 1301, 52d Leg., 1st Sess. (1979); Del., H.R. 570, 130th Leg. (1979); Ky., H.R. 265, Reg. Sess. (1976); La., H.R. 1085 (1979); Va., H.R. 872 (1980); Wis., A. 1086 (1977).

be located.[244] A Georgia proposal requires the consent of all of one's children, but in the absence of that allows a physician to petition the court for an order allowing him to remove the life support system.[245]

A few bills have other consent provisions. In some, court review is mandated in all cases.[246] In one, the withholding of therapy must be approved by the attending physician and the executive committee of the medical staff of the hospital or, alternatively, by the attending physician and the medical director of the nursing home in which the patient lives.[247] Such provisions contemplate review of the decision itself, not just certification of certain medical facts. They thus cut a wide swath in the very basis of legislative action—the presumed autonomy of the individual patient. It is difficult to see what rationale justifies such provisions.

Many of the bills have special consent provisions for patients in nursing homes.[248] Generally, they require that the "living will" of a nursing home patient be certified by an ombudsman or special representative appointed by the state. The justification offered for these provisions is that nursing home patients "may be so insulated from a voluntary decision-making role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willfully and voluntarily executing a directive."[249] This concern is surely valid, but the solution may be more illusory than real. Somewhat analogous provisions that make the state a guardian for noninstitutionalized retarded persons have been less than successful in promoting similar goals of autonomy and welfare. There may be no other feasible alternative at this juncture, but it is helpful to recognize the limitations of this procedure.[250]

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244. Del., H.R. 30, 128th Leg., 1st Sess. (1975); Va., H.R. 872 (1980). In some states court approval is necessary before third parties may consent to the removal of care. Colo., H.R. 1301, 52d Leg., 1st Sess. (1979); Del., H.R. 570, 130th Leg. (1979); Ky., H.R. 265, Reg. Sess. (1976); N.Y., S. 8932 (1976); Wis., A. 1086 (1977).

245. Ga., H.R. 630 (1977).

246. Ky., H.R. 265, Reg. Sess. (1976).

247. Ga., H.R. 630 (1977).

248. Del., H.R. 2, 129th Leg., 1st Sess. (1977); Fla., H.R. 740 (1979); Ga., H.R. 630 (1977); Iowa, H.R. 235 (1978); La., H.R. 1240 (1977); S.C., H.R. 2419 (1977).

249. S.C., H.R. 2419 (1977).

250. Levy, *Protecting the Retarded: An Empirical Survey and Evaluation of the Establishment of State Guardianship in Minnesota*, 49 MINN. L. REV. 821 (1965).

*3. The Form of the Document*

Most of the proposals, especially those of more recent vintage, specify the form the declaration must take.[251] In some instances, the prescribed form adopts different language in describing the threshold than do the other sections of the bill. This is a serious problem, as noted above.[252] One proposed form contains an explicitly religious declaration that is surely suspect constitutionally. The declaration reads in part: "Appearer stated that he believes that God our Father has entrusted to him a shared dominion with Him over his earthly existence so that he is bound to use ordinary means to preserve [his] life but is free to refuse extraordinary means to prolong his life."[253] Aside from the first amendment problems, this provision creates other difficulties because it conflicts with other sections of the same bill in that it uses a treatment threshold, while the other sections employ a terminality threshold.

*4. The Context in Which the Declaration May or Must Be Honored*

Many of the bills follow the lead of the California statute by endorsing the two-tiered approach discussed earlier.[254] If the patient is diagnosed as terminal at least fourteen days before he signs the declaration, it is conclusively presumed to reflect the wishes of the patient, and it must be honored. Otherwise, unless re-executed, the document may be viewed as an expression of the patient's beliefs, but it need not be respected.[255] The criticisms already advanced concerning this scheme[256] need not be repeated.

Several of the bills require that the physician determine the competency of the patient. If the patient is competent, his present wishes must be respected regardless of the existence of a

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251. Ky., H.R. 265, Reg. Sess. (1976); La., H.R. 1240 (1977); Mass., H.R. 1096 (1980); Miss., S. 2483, Reg. Sess. (1979); Mont., S. 75 (1977); N.Y., S. 5514-A, Reg. Sess. (1979); Okla., H.R. 1344, 36th Leg., 1st Sess. (1977); S.C., H.R. 2419 (1977); Utah, H.R. 11, Reg. Sess. (1977); Wis., A. 779 (1979); Wis., A. 1086 (1977).

252. *See supra* text accompanying note 193.

253. La., H.R. 1240 (1977).

254. *See supra* text accompanying notes 210-12.

255. Del., H.R. 2, 129th Leg., 1st Sess. (1977); La., H.R. 1240 (1977); Md., S. 60 (1977); Mont., S. 75 (1977); N.H., H.R. 291 (1979); N.H., H.R. 300 (1977); N.Y., A. 65, Reg. Sess. (1980); Okla., H.R. 1128, 37th Leg., 1st Sess. (1979); S.C., H.R. 2419 (1977); Wis., A. 1086 (1977).

256. *See supra* text accompanying notes 210-12.

previously signed document. Such provisions may be superfluous, but it may be helpful to have this elementary principle clearly restated in the statute.[257]

### 5. *Penalties for Falsifying or Failing to Comply with the Declaration*

The penalties for not honoring a declaration vary from bill to bill. Many bills provide no penalties. Those that do usually go no further than to provide that a physician who neither honors a request nor transfers the patient to a physician who will can be cited for unprofessional conduct.[258] One bill provides that this is a misdemeanor offense, but it provides no set penalty.[259]

There are stricter penalties for falsifying a document. Most bills provide for at least misdemeanor punishment.[260] Some provide that falsification which leads to a person's death is punishable as homicide.[261] Given the seriousness of the situation, strict penalties for falsification are surely in order. And, as in the case of the statutes already enacted, the absence of penalties for failure to honor a declaration is a serious problem.[262] If liability for acting under a declaration is removed, as it is in almost all of these bills, then penalties ought to be provided for failure to so act.

### 6. *Miscellaneous Provisions*

The bills also contain a number of miscellaneous provisions.

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257. Del., H.R. 1214, 128th Leg., 2d Sess. (1976); Md., S. 388 (1979); N.Y., S. 5514-A (1980); Wis., A. 779 (1979).

258. *E.g.*, Ga., H.R. 630 (1977); Iowa, H.R. 2351 (1978); Md., S. 60 (1977); Mont., S. 75 (1977); N.H., H.R. 291 (1979).

259. Ind., H.R. 1366 (1977); Mass., H.R. 1096 (1980) (provides civil liability for failure to comply).

260. Alaska, H.R. 632, 10th Leg., 2d Sess. (1978); Ariz., S. 1146, 32d Leg., 2d Sess. (1978); Colo., H.R. 1301, 52d Leg., 1st Sess. (1979); Del., H.R. 2, 129th Leg., 1st Sess. (1977); Fla., H.R. 463 (1980); Ga., H.R. 630 (1977); Hawaii, H.R. 1510, 10th Leg. (1979); Ind., H.R. 1366 (1977); La., S. 578, Reg. Sess. (1977); Mich., H.R. 4058 (1979); Mont., S. 75 (1977); N.H., H.R. 291 (1979); N.Y., A. 65, Reg. Sess. (1980); Okla., S. 83, 37th Leg., 1st Sess. (1979); Va., H.R. 1595 (1975); Wis., A. 779 (1979).

261. Alaska, H.R. 632, 10th Leg., 2d Sess. (1978); Colo., H.R. 1301, 52d Leg., 1st Sess. (1979); Del., H.R. 2, 139th Leg., 1st Sess. (1977); Fla., H.R. 463 (1980); Ga., H.R. 630 (1977); Hawaii, H.R. 1510, 10th Leg. (1979); Ind., H.R. 1366 (1977); Iowa, H.R. 2351 (1978); La., S. 578, Reg. Sess. (1977); Mass., H.R. 3515 (1979); Mich., H.R. 4058 (1979); Mont., S. 75 (1977); N.H., H.R. 291 (1979); Okla., S. 83, 37th Leg., 1st Sess. (1979); S.C., H.R. 2419 (1977); Wis., A. 779 (1979).

262. *See supra* text accompanying note 221.

Some provide that a declaration is valid for only a certain period of time (usually five years) and that subsequently it must be re-executed to be valid.[263] Others do not so specify.[264] Many bills provide that actions under the terms of a declaration are neither suicide nor mercy killings.[265] These propositions may or may not withstand scrutiny depending on the threshold standard adopted. Many bills explicitly specify the means for revoking a document,[266] and most provide that the bill, or a declaration signed in conformity with the bill, will have no effect on the sale of insurance.[267] This is a useful provision, but none of the bills provide either a means of enforcing it or penalties for those insurors who disregard it. Many bills wisely contain pregnancy exceptions (e.g., no termination of treatment during pregnancy),[268] but some do so in the contradictory context of a previously stated "immediacy" threshold.[269] The pregnancy period is surely longer than the period that would be covered under any reasonable interpretation of an immediacy standard. Finally, some bills explicitly state that they in no way impinge on any right previously held by a patient.[270] These provisions are apparently

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263. Del., H.R. 2, 139th Leg., 1st Sess. (1977); Fla., H.R. 463 (1980); Ga., H.R. 630 (1977); Hawaii, H.R. 1510, 10th Leg. (1979); Ind., H.R. 1336 (1977); Iowa, H.R. 2351 (1978); La., S. 578, Reg. Sess. (1977); Mass., H.R. 3515 (1979); Mont., S. 75 (1977); N.H., H.R. 300 (1977); N.Y., A. 65, Reg. Sess. (1979); Okla., H.R. 1128, 37th Leg., 1st Sess. (1979); S.C., H.R. 2419 (1977); Wis., A. 1086 (1977).

264. Colo., H.R. 1301, 52d Leg., 1st Sess. (1979); Del., H.R. 557, 130th Leg. (1979); Iowa, H.R. 2062 (1980); Mich., H.R. 4058 (1979); Miss., S. 2483, Reg. Sess. (1979); N.H., H.R. 291 (1979); Okla., S. 83, 37th Leg., 1st Sess. (1979); Pa., S. 1110 (1977); Va., H.R. 872 (1980).

265. Recent bills from Arizona, Colorado, Utah, New York, Massachusetts, Michigan, Virginia, Wisconsin, Georgia, Oklahoma, Mississippi, Delaware, Florida, Iowa, New Hampshire, Montana, Alaska, Indiana, Louisiana, South Carolina and Hawaii make these claims.

266. Every proposal I have seen makes some such provision.

267. Draft bills from Delaware, Mississippi, Colorado, Florida, Iowa, Louisiana, Hawaii, South Carolina, Maryland, Pennsylvania, New Hampshire, Alaska, Montana, Georgia, Oklahoma, Wisconsin, Michigan, Massachusetts, New York and Utah contain provisions stating that the sale of insurance shall not be affected.

268. Alaska, H.R. 632, 10th Leg., 2d Sess. (1978); Del., H.R. 2, 129th Leg., 1st Sess. (1977); Fla., H.R. 463 (1980); Ga., H.R. 630 (1977); Hawaii, H.R. 1510, 10th Leg. (1979); Iowa, H.R. 3451 (1978); Md., S. 388 (1979); Mont., S. 75 (1977); N.H., H.R. 291 (1979); N.Y., S. 7932 (1978); Okla., H.R. 1128, 37th Leg., 1st Sess. (1977); S.C., H.R. 2419 (1977); Wis., A. 779 (1979).

269. Alaska, H.R. 632, 10th Leg., 2d Sess. (1978); Del., H.R. 2, 129th Leg., 1st Sess. (1977); Fla., H.R. 463 (1980); Ga., H.R. 630 (1977); Hawaii, H.R. 1510, 10th Leg. (1979); Mass., H.R. 1086 (1979); Mont., S. 75 (1977); N.H., H.R. 291 (1979); N.Y., S. 7932 (1978); Okla., H.R. 1128, 37th Leg., 1st Sess. (1977); S.C., H.R. 2419 (1977); Wis., A. 779 (1979).

270. Alaska, H.R. 632, 10th Leg., 2d Sess. (1978); Ga., H.R. 630 (1977); Hawaii, H.R.

designed to counter one of the most persuasive arguments against such legislation, namely, that it will make illegal any termination of treatment outside the provisions of the law and will thus restrict previously held common-law rights. Depending on what one thinks those common-law rights are, or what one believes they ought to be, this may be an important issue. Thus the inclusion of such a provision may therefore be justified.

Some of the problems with these statutes and proposed statutes are easily remedied. Nevertheless, it remains true that the attempt to provide statutory guidance for patients and physicians is inherently problematic. To the extent that statutory coverage is provided for cases like *Quinlan,* in which the patient is not terminal, crucial dangers emerge. These dangers have been well highlighted by the ways in which courts have adopted crude "quality of life" criteria when faced with these decisions.[271] In many cases these criteria amount to little more than the bold assertion that a given person ought not to live anymore because the court believes that his diminished state makes his life worthless. Any attempt to provide statutory coverage for such situations clearly poses immense dangers to the fundamental premise of our legal philosophy, namely, the equal minimal worth (and hence rights) of each human being, irrespective of his diminished physical or mental capacities.[272]

On the other hand, the kinds of limitations one finds in the existing laws render their usefulness deeply suspect. Under existing common-law principles, individuals may refuse medical care. They do not need living will legislation in order to assert this right. The available evidence suggests that even when living will legislation exists, the vast majority of patients will not make use of it. They will continue to refuse therapy on the basis of the time-honored common-law right.[273] Further, there are no re-

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1510, 10th Leg. (1979); Iowa, S. 2062 (1980); La., H.R. 1240 (1977); Md., H.R. 388 (1979); Mass., H.R. 3515 (1979); Mich., H.R. 4058 (1979); N.H., H.R. 291 (1979); N.Y., S. 5514-A, Reg. Sess. (1979); S.C., H.R. 2419 (1977); Wis., A. 1086 (1977).

271. *See supra* text accompanying notes 117-88.

272. Sherlock, *Liberalism, supra* note 11. The centrality of this form of "equality" in the American regime is discussed best in H. JAFFA, HOW TO THINK ABOUT THE AMERICAN REVOLUTION (1977).

273. After California passed its pioneering "natural death act" the California Medical Association conducted a survey of a cross section of California physicians. Almost half said that the act merely gave legal sanctions to actions that they would have taken anyway without the act. Another large group of physicians had no occasion to make use of the act and thus could not comment on how it might have affected their practice. It seems clear that when these groups are considered together the natural death act had

corded cases in which a physician has been held liable for the removal of medical measures that cannot save the patient's life, even if the patient is comatose, as long as the physician acts with the consent of the family. Such actions are common in any large hospital, and will undoubtedly continue with or without legislation. Moreover, only three of the current laws and only a handful of the proposed statutes give any guidance for the great majority of cases in which the individual becomes terminally ill and incompetent without having executed the required form.

Finally, there is a danger in strictly following the statutes. By setting forth strict procedural requirements which the physician must follow, the statutes implicitly render the physician liable for failure to follow the prescribed format. Fear of this liability may actually deter a physician from making a decision to withdraw useless therapy from those who have not executed the required form prior to becoming incompetent. In short, far from enhancing the physician's opportunity to offer humane treatment to the terminally ill, these statutes may actually foster the opposite result by requiring that the physician strictly obey the statute in every situation.[274]

## VI. Conclusion

The law is a blunt and often inadequate means of political governance. The law has limits, both in the range of human endeavor that it can effectively regulate and in the ends that it can effectively foster. Law and public policy cannot save us from our sins, or endow us with saintly virtue. Law is a precondition of justice and virtue, but it is a mistake to equate the order that law can impose with true virtue.[275] Law can help preserve the central values of a society and restrain the vilest of human deeds. Without it, political regimes, especially liberal regimes, cannot be maintained, but law alone cannot do all that must be done if these regimes are to survive and prosper.

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little impact on the actual outcome of clinical practice. It did seem to have a positive impact on the ability of physicians to discuss these matters openly with their patients. California Medical Association, *Survey Results Following One Year's Experience with the Natural Death Act*, Sept. 1977, *reprinted in* 315 Annals of N.Y. Acad. of Sci.

274. These fundamental problems with living will legislation are discussed in Horan & Marzen, *supra* note 191.

275. Most of the great political philosophers, especially Plato, understood this point. One of the best recent discussions of it is found in I. Jenkins, Social Order and the Limits of Law (1980).

Those who ask that the right to die be given legal recognition ask for something that no liberal regime can safely give without abandoning its most fundamental principles in favor of crude, vaguely worded claims that some human lives do not merit the most primitive protections any society can provide its members. This article has analyzed the arbitrary, incoherent attempts of commentators, courts, and legislators to fashion such a right in language precise enough to limit its application, but broad enough to cover the case at hand. As has been shown, such attempts create problems and dangers which cannot be disregarded.

Roscoe Pound once wrote that "law prevents sacrifice of ultimate interests, social and individual, to the more obvious and pressing but less weighty immediate interests."[276] This is surely true. But in a legalistic age such as ours, law can also be twisted to serve the immediate needs of the few with little regard for the broader interests of the regime within which law takes shape. This is the fundamental dilemma that confronts us today with the demands to legalize the practice of euthanasia in its various forms. If this article stimulates interest in the immensely problematic nature of such proposals, its purposes will have been achieved.

276. Pound, *Justice According to Law*, 13 COLO. L. REV. 706 (1913).