

1977

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Recommended Citation

Becker, Douglas W.; Fleming, Robert W.; and Overstreet, Rebecca M. (1977) "The Legal Aspects of the Right to Die: Before and After the Quinlan Decision," *Kentucky Law Journal*: Vol. 65 : Iss. 4 , Article 4.

Available at: <https://uknowledge.uky.edu/klj/vol65/iss4/4>

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NOTE

THE LEGAL ASPECTS OF THE RIGHT TO DIE: BEFORE AND AFTER THE *QUINLAN* DECISION

INTRODUCTION

Recently the New Jersey Supreme Court confronted the complex legal and social issues surrounding an individual's "right to die."¹ The question whether life-prolonging measures should be utilized by the medical profession to prevent the natural death of one who is in an irreversible unconscious state was presented to the court in what many consider the most celebrated case of this decade.

This question has burdened the medical profession since the development of life-prolonging devices. Prior to *In re Quinlan*, however, the medical profession dealt with the issue without judicial interference or guidance.² Before the *Quinlan* litigation it was common practice for the family and the physician, or the physician alone, to make the decision as to "when artificial life support mechanisms are to be withdrawn from a person who will never regain consciousness."³ As a result of the recent rise in medical malpractice litigation, the medical profession has called upon the courts to resolve the issue of when life-prolonging devices may be withdrawn from a patient.⁴

¹ *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

² B. COLEN, *KAREN ANN QUINLAN—DYING IN THE AGE OF ETERNAL LIFE* (1976).

³ Note, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALBANY L. REV. 826, 837 (1975)[hereinafter cited as *Voluntary Euthanasia: A Proposed Remedy*]. See also Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202 (1973)[hereinafter cited as *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*].

⁴ COLEN, *supra* note 2, at 52. The physicians treating Karen were aware of the legal problems they faced in an era where malpractice has come to mean treating unsuccessfully rather than treating improperly.

We know, for instance, that the same week the Quinlans filed their petition in Superior Court, Dr. Ashad Javed [one of Karen's physicians] contacted his malpractice insurance carrier, told them he was concerned, and asked for legal assistance. The malpractice carrier, Chubb & Son, Inc., provided Dr. Javed with the services of Ralph Porzio. Porzio was described . . . by . . . Chubb's vice president for claims, as "probably one of the most distinguished legal-medical men in the state We were responsible for

Due to the growing number of people who reach old age and the increase in the incidence of diseases such as cancer,⁵ there is growing interest in the practice of euthanasia.⁶ Several factors indicate that the public favors the practice of euthanasia in certain circumstances. First, there is no doubt that members of the medical profession do practice euthanasia.⁷ In terms of equality for patients who have serious medical problems, it is imperative that a legal precedent be established on this issue. Until such a precedent is established, doctors will continue to practice euthanasia at their own discretion, placing patients being treated by different doctors in inequitable positions.

Secondly, an increasing majority of people in this country are in favor of allowing some form of euthanasia. Two Gallup polls, one in 1950 and another in 1973, showed an increase in

his bills . . . I don't know if [a possible malpractice] suit was *their* man's fear, but it was the basis on which [Javed] came to us. They must have been concerned about it."

Id. at 52-53.

⁵ Gurney, *Is There a Right to Die?—A Study of the Law of Euthanasia*, 3 CUM.-SAM. L. REV. 235, 236 (1972).

⁶ The word "euthanasia" is of Greek origin. The literal translation is "good death," coming from *eu-*, meaning "good," and *thanatos*, meaning "death." WEBSTER'S NEW INTERNATIONAL DICTIONARY 786 (3d ed. 1966). Webster defines euthanasia as "(1) an easy death or means of inducing one" and "(2) the act or practice of painlessly putting to death persons suffering from incurable conditions of disease." *Id.* Black's definition is narrower, defining euthanasia as "[t]he act or practice of painlessly putting to death persons suffering from incurable and distressing disease." BLACK'S LAW DICTIONARY 654 (rev. 4th ed. 1968).

There is disagreement over whether euthanasia encompasses acts of commission only, HEIFETZ, *THE RIGHT TO DIE* 96 (1975) or acts of both commission and omission. Comment, *The Right to Die*, 10 CAL. W. L. REV. 613 (1974); Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 351 n.5 (1954). The authors of this Note will assume the word "euthanasia" includes acts of both omission and commission. However, when the term is used it will be preceded by the word "active" (meaning that death was caused by an act that hastened the patient's death) or the word "passive" (meaning that death was caused by natural expiration because extraordinary medical procedures were never administered or were withdrawn) when the distinction is necessary.

⁷ In one survey, 61% of the doctors responding to questionnaires admitted practicing some form of euthanasia. 8 J. OF FOR. MED. 57, 68 (1961) and TURBO, AN ACT OF MERCY: EUTHANASIA TODAY, 42-43 (1973), cited in *Voluntary Euthanasia: A Proposed Remedy*, *supra* note 3, at 826. Another survey of doctors indicated that 44% of the respondents frequently omitted life-prolonging procedures and medications. 5 INT'L J. OF PSYCH. IN MED. 18, 19 (1974), while a third survey indicated that as many as 80% of the doctors questioned practiced euthanasia. 218(1) J.A.M.A. 249 (1971).

the number of people favoring active euthanasia from 36 to 53 percent.⁸ Another poll indicated 76 percent of the respondents were in favor of euthanasia legislation.⁹ Proposed euthanasia legislation has been before legislatures in a number of states,¹⁰ and just recently euthanasia legislation became law in California.¹¹ Reaction to this type of legislation, however, has not always been favorable.¹²

A third factor indicating that public sentiment is in favor of euthanasia is the fact that in criminal cases involving active euthanasia the jury usually fails to convict the defendant of first degree murder,¹³ even though most authorities agree that all of the elements of first degree murder are present.¹⁴ For example, in the case of Dr. Vincent Montmarano, the defendant had allegedly given an injection of potassium chloride to a cancer patient who was expected to die within 48 hours.¹⁵ Although the evidence clearly indicated that the defendant was

⁸ 14(3) MED. WORLD NEWS 73, 74-75 (Sept. 14, 1973).

⁹ 8 J. OF FOR. MED. 47, 77 (1961).

¹⁰ Between 1971 and 1974, at least 10 states considered euthanasia legislation. Of the 10 bills drafted, eight proposed passive euthanasia (Del. H.B. 251 (1973); Fla. H.B. 407 (1973); Md. H.B. 700 (1974); Mass. H.B. 3641 (1974); Ore. H.B. 2997 (1973); Wash. S.B. 2449 (1973); W.Va. S.B. 358 (1972); Wis. S.B. 670 (1971)) and two proposed active euthanasia (Mont. H.B. 137 (1973); Ore. H.B. 179 (1973)). *Voluntary Euthanasia: A Proposed Remedy*, *supra* note 3, at 826 n.3. For a summary by the sponsor of the Florida bill, see 64(3) S. MED. J. 300 (1971).

¹¹ California Assembly Bill No. 3060, Ch. 1439, adding Ch. 3.9 (commencing with Section 7185) to Part 1 of Division 7 of the Health and Safety Code, relating to medical care [hereinafter cited as California Assembly Bill No. 3060]. For a discussion of this bill see Conclusion and text accompanying notes 54-68, *infra*.

¹² An Oregon bill precipitated a landslide of outraged mail and full-page newspaper advertisements advocating the bill's defeat. 14(1) MED. WORLD NEWS 5 (March 23, 1975).

¹³ There are no reported cases in which a physician has been prosecuted for omitting or discontinuing the use of extraordinary medical measures. Gurney, *supra* note 5, at 248; *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 3, at 1202, 1208.

¹⁴ Kasimar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 970 n. 9 (1958); Silving, *supra* note 6, at 352-53; CURRAN & SHAPIRO, LAW, MEDICINE AND FORENSIC SCIENCE 130 (1970) and WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 318-19 (1970), cited in Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 259 (1973). Motive is irrelevant in a homicide case: to be guilty of murder the defendant need only have the intent to kill. Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 540 (1969).

¹⁵ N.Y. Times, Jan. 13, 1974, at 44, col. 4.

guilty,¹⁶ the jury acquitted on the first ballot after only 55 minutes of deliberation.¹⁷ In the only other case in this country in which a physician was tried for murder for allegedly practicing active euthanasia, the defendant was also acquitted.¹⁸ Juries show the same reluctance to convict non-medical defendants who allegedly have practiced active euthanasia.¹⁹

Society finds euthanasia less reprehensible than the usual case involving homicide and this is reflected in the jury's decision. However, as a result of jury reluctance to convict, offenders are being treated inequitably²⁰ and a gap is arising in the legal system.²¹ One group of authors asserts that by failing to treat the euthanasia defendants as murderers, the state is denying the victims both due process and equal protection; and conversely, that by convicting others as murderers, the state may be exacting a cruel and unusual punishment.²² "Public confidence in the administration of criminal justice is hardly strengthened when moral issues are shifted . . . , or when the law relegates to juries the function of correcting its inequities."²³

This Note will cover a variety of areas pertaining to the withholding and withdrawing of medical treatment. In doing so, the problems facing the *Quinlan* court will be analyzed so that its decision may be better understood. This Note will also discuss *In re Quinlan* in depth and the issues not resolved by that decision. Finally, a "Right to Natural Death Act" will be proposed.²⁴

¹⁶ N.Y. Times, Jan. 22, 1975, at 35, cols. 1 and 4; N.Y. Times, Jan. 24, 1974, at 34, col. 4.

¹⁷ N.Y. Times, Feb. 6, 1974, at 1, col. 1.

¹⁸ 14(3) MED. WORLD NEWS 73 (Sept. 14, 1973).

¹⁹ A study of 12 cases involving active euthanasia revealed one failure to indict, seven acquittals, three convictions for an offense less than murder, and only one conviction for murder itself. *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 3, at 1213. See also Silving, *supra* note 6, at 353; Kutner, *supra* note 14, at 540-51.

²⁰ Silving, *supra* note 6, at 354.

²¹ Kutner, *supra* note 14, at 542.

²² *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 3, at 1229.

²³ Silving, *supra* note 6, at 354.

²⁴ This Note will discuss current cases concerning the right to die and the ramifications of those cases. It is an objective analysis of law which is not intended to reflect any particular religious or philosophical viewpoint.

I. THE STATE OF THE LAW PRIOR TO THE QUINLAN DECISION

A. *The Basis for Refusal and Withdrawal of Medical Treatment*

1. *The Doctor-Patient Relationship*

The "right" of an individual to determine when bodily invasion in the form of medical treatment will occur is not a new concept in the law. The right stems from the basic principle that each person has a right to self-determination over his own body.²⁵ John Stuart Mill recognized this right in 1873 when he stated: "Each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest."²⁶ The United States Supreme Court first recognized that individuals are sovereign over their own persons in *Union Pacific Railway v. Botsford*.²⁷ In repudiating attempts to compel a personal injury plaintiff to undergo pre-trial medical examination, the Supreme Court commented:

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference by others, unless by clear and unquestionable authority of law.²⁸

The medical patient's right to bodily control has been embodied in the tort doctrine of informed consent. Absent an emergency, no medical procedure or treatment may be performed by a physician without the patient's consent.²⁹ Such consent may be obtained only after explanation of the nature of the treatment, the risks involved, and alternative therapies.³⁰ The theory behind the requirement of informed consent

²⁵ Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1634 (1973). This principle implies that there exist categories of decisions which an individual must be permitted to make, even if others believe the individual decides irrationally or incorrectly. See 2 F. HARPER & F. JAMES, *THE LAW OF TORTS* 61 (Supp. 1968).

²⁶ J.S. MILL, *On Liberty*, in JOHN STUART MILL: *THREE ESSAYS* at 18 (1975).

²⁷ 141 U.S. 250 (1891).

²⁸ *Id.* at 251.

²⁹ *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. 1951); Annot., 9 A.L.R. 1391, 1392 (1966).

³⁰ See generally Note, *Informed Consent as a Theory of Medical Liability*, 1970

is variously expressed as assault, battery, negligence, malpractice, or even trespass, but the underlying concept of protection of bodily integrity remains the crux of informed consent.

Judge Cardozo articulated the doctrine well when he stated:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his consent commits an assault, for which he is liable. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained.³¹

One court has acknowledged that the exercise of self-determination by the patient may mean the refusal of lifesaving assistance.

Anglo-American Law starts with the premise of thoroughgoing self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of a patient by any form of artifice or deception.³²

The doctrine of informed consent involves two elements: (1) The patient must be given all pertinent information about his condition, and (2) he must assent to treatment.³³ Thus the competent patient retains control over decisions about treatment even if he is suffering from a terminal illness.³⁴ The logical

Wis. L. REV. 879; Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533 (1970); Comment, *Failure to Inform as Medical Malpractice*, 23 VAND. L. REV. 754 (1970).

³¹ Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (citation omitted).

³² Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960). See also Woods v. Brumlop, 377 P.2d 520, 524 (N.M. 1962). There is an exception to the informed consent requirement in "emergency situations" based on the patient's incapacity and the presumption that the patient would, if physically able, authorize medical treatment. See Note, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 CAL. L. REV. 860 (1965); Note, *The Right to Die*, 7 Hous. L. REV. 654 (1970).

³³ Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1636 (1974).

³⁴ *Id.* at 1635.

extension of this doctrine is that the patient has the right to refuse treatment and to withdraw consent at any time.

The patient's right to an informed consent makes no sense without a right to an informed refusal. The right to refuse should be extended to the dying patient, for his decision on preferred treatment is no different from that involved in any other medical situation. The individual continues to know best his own value preferences, capacity for pain and suffering, and uncompleted business and social obligations. He remains the optimal cost avoider.³⁵

In contradiction to the statements above are the few cases in which courts have held that a patient, once he consents to treatment, submits to the ethics of the attending physician. In *United States v. George*³⁶ the court reviewed an order permitting a hospital to administer blood transfusions which were contrary to the religious beliefs of the patient.³⁷ In discussing the need for respect of the doctor's conscience in such a case, the court stated that where the patient voluntarily submitted himself to and insisted upon medical care but simultaneously sought to dictate to treating physicians a course of treatment amounting to medical malpractice, it would be unjustifiable to require the doctors to ignore the mandates of their own consciences, even in the name of free religious exercise.³⁸ Faced with a similar situation, the Supreme Court of New Jersey commented that the court should consider "the interest of a hospital or its staff when the patient is thrust upon them."³⁹ However, these cases involve the situation in which the patient desires medical care but insists that care be restricted by refusing to consent to blood transfusions. In the typical passive euthanasia case, the patient will reject all medical treatment (except possibly the administration of pain-relieving drugs) instead of requesting a restricted form of treatment. In addition, the interests of a physician are not a valid state interest

³⁵ *Id.* at 1648.

³⁶ 239 F. Supp. 752 (D. Conn. 1965).

³⁷ For a discussion of cases concerning the right to refuse medical treatment based on the first amendment freedom of religion, see text accompanying notes 74-98.

³⁸ 239 F. Supp. at 754.

³⁹ *John F. Kennedy Memorial Hosp. v. Heston*, 279 A.2d 670, 674 (N.J. 1971).

as is required to override an individual's constitutional rights,⁴⁰ and are insufficient to justify a violation of the patient's constitutional rights.

Since the patient must consent before he may be treated, and since he has the power to withdraw that consent, he also has the power to consent to treatment until specified events occur.⁴¹ A person who must undergo a serious medical operation has the authority to limit his consent to treatment. That person may order his physician to discontinue treatment if recovery from the operation is incomplete and he is in an irreversible unconscious state. The patient, prior to the operation, must make it clear to the physician under what circumstances his consent is withdrawn.

Obviously, circumstances do exist in which the patient should not be informed of his condition. The physician must consider the patient's ability to understand the proposed procedures and his emotional capacity to cope with the consequences of his condition.⁴² However, there are many instances in which a patient can comprehend his situation, accept it, and make a rational decision based on the facts. When such occasions arise, the patient should have the opportunity to refuse treatment or to specify that his consent to treatment is withdrawn if certain events occur.⁴³ This would force the attending physician to obtain a court order to begin or to continue treatment.⁴⁴

2. *The Living Will*

One of the indications of the public's acceptance of euthanasia is the increased popularity of the living will.⁴⁵ In es-

⁴⁰ See text accompanying notes 74-98 for a discussion of the right to refuse medical treatment on the basis of the first amendment.

⁴¹ HEIFETZ, *supra* note 6, at 29-30.

⁴² *Id.* at 26.

⁴³ Some physicians absolutely reject the contention that a patient has the power to specify that under certain circumstances medical treatment must be withdrawn. For comments by a physician concerning this issue, see HEIFETZ, *supra* note 6, at 13-17.

⁴⁴ If consent is withdrawn by the patient, the physician's duty is terminated. For there to be any criminal liability on the part of the doctor, a duty must exist. Therefore, when consent is withdrawn, so is the basis for criminal liability. *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 3, at 1208.

⁴⁵ When columnist Ábigail Van Buren advocated the use of the living will, 40,000

sence this document states that the signatory *requests* that he not be kept alive by artificial means or heroic measures if there is no reasonable expectation of recovery from physical or mental disability.⁴⁶ The living will is not meant to have any binding effect; rather it is an expression of the signatory's wishes. Authorities agree that it has no legal effect,⁴⁷ though there appears to be no case law on the subject. Authorities disagree⁴⁸ on whether a document similar to the living will with a binding effect on the physician could be written.⁴⁹

Obviously there are many problems associated with a document which would legally force a physician to withdraw life-sustaining procedures from a patient: the doctor would have to be protected from criminal liability; the performance of the contract would have to be enforced by a third party if the signatory were incapacitated; and the terms would have to be broad enough to cover a number of different situations without being so vague as to be unenforceable.⁵⁰ Any problems concerning the criminal liability of the doctor would be resolved in favor of the doctor's innocence. The document would relieve the physician from any duty to care for the patient and there can be no criminal liability absent a duty on the part of the doctor.⁵¹ The problem of having a third party enforce the document in the event of the signatory's incapacitation could be resolved by court appointment of a guardian for that purpose, or by allowing the signatory to execute a power of attorney for

requests for copies of it were received within two weeks. As of the end of 1973, 300,000 living wills had been distributed. HEIFETZ, *supra* note 6, at 168.

⁴⁶ For the text of the living will, see *The Courier-Journal*, Nov. 10, 1975, § A, at 6, col. 1; HEIFETZ, *supra* note 6, at 37-38.

⁴⁷ *The Courier-Journal*, Nov. 10, 1975, § A, at 6, col. 1; HEIFETZ, *supra* note 6, at 38; Vodiga, *Euthanasia and the Right to Die—Moral, Ethical and Legal Perspectives*, 51 CHI.-KENT L. REV. 1, 12 (1974); Note, *Antidythanasia Contracts: A Proposal for Legalizing Death with Dignity*, 5 PAC. L. J. 738, 739 (1974). The California Medical Society commissioned legal research to study the effects of the living will. The conclusion reached was that the document "would probably not carry any weight in court." HEIFETZ, *supra* note 6, at 38 (citing *Los Angeles Medical Association Bulletin*, Nov. 15, 1973).

⁴⁸ Vodiga, *supra* note 47, at 12.

⁴⁹ HEIFETZ, *supra* note 6, at 36-38; Note, *supra* note 47, at 738.

⁵⁰ Note, *supra* note 47, at 740.

⁵¹ *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 3, at 1208.

this purpose before incapacitation.⁵² The problems concerning vagueness are not substantial, especially in the situation where the patient is aware in advance that he may become incapacitated due to a specific medical condition.⁵³

3. *Euthanasia Legislation*

Legislation in this area could relieve substantially all the problems in connection with an enforceable living will.⁵⁴ California has recently enacted such a statute.⁵⁵ California's Natural Death Act is a very detailed piece of legislation which expressly authorizes "the withholding or withdrawal of life-sustaining procedures . . . from adult patients afflicted with a terminal condition . . . where the patient has executed a directive in the form and manner prescribed by the bill."⁵⁶ The Act is, however, very limited—before an individual can execute a directive he must be afflicted with a terminal condition.⁵⁷ Terminal condition is defined as "an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve [*sic*] only to postpone the death of the patient."⁵⁸ The statute requires that the terminal condition be diagnosed by two physicians.⁵⁹ The legislation pre-

⁵² In Kentucky the power of attorney does not cease with the disability of the principal. KY. REV. STAT. § 386.093 (1972)[hereinafter cited as KRS].

⁵³ Again the example of a person about to undergo a serious operation is illustrative. See text accompanying notes 32-35 *supra*. Before the operation the doctor would be able to predict the possible outcomes, although he might not be able to predict which one will actually occur. The patient could then decide which outcomes to include in the document as conditions under which he would no longer wish to be maintained. Even without the situation in which the patient knows he will be undergoing an operation from which he might not fully recover, it should be possible for a person to decide under which conditions he does not desire to be maintained by machines, and to enumerate those situations in a document for use if he is ever ill without warning.

⁵⁴ For proposed euthanasia statutes, see HEIFETZ, *supra* note 6, at 40-42; *Voluntary Euthanasia: A Proposed Remedy*, *supra* note 3; Note, *supra* note 47; Kutner, *supra* note 14. For a summary of states which have had proposed euthanasia statutes before their legislatures, see note 10 *supra*.

⁵⁵ California Assembly Bill No. 3060, *supra* note 11.

⁵⁶ Legislative Counsel's Digest to California Assembly No. 3060, *supra* note 11.

⁵⁷ California Assembly Bill No. 3060, *supra* note 11, § 1 (7187(e)).

⁵⁸ *Id.* § 1 (7187(f)).

⁵⁹ *Id.* § 1 (7187(e)).

vents a rash decision by requiring the patient to state that his condition was revealed to him by a physician (whose name must be stated in the directive) at least 14 days before the signing of the document.⁶⁰

The statute provides a number of safeguards for the patient.⁶¹ The directive can be orally revoked without regard to the patient's mental state or competency.⁶² Even if not revoked, the document becomes ineffective 5 years from the date of execution.⁶³ "Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another" without the declarant's consent is guilty of a misdemeanor.⁶⁴ Any person who forges the directive of another, or withholds or conceals knowledge of a revocation, with the intent to cause a withholding or withdrawing of life-sustaining procedures contrary to the wishes of the declarant is subject to prosecution for unlawful homicide.⁶⁵

As any legislation concerning this subject must, this bill insulates the physician and health facility from civil and criminal liability.⁶⁶ In addition, the withholding or withdrawing of life-sustaining procedures in accordance with the Act does not constitute homicide by express provision of the statute,⁶⁷ and the act of making a directive does not affect life insurance policies in any way.⁶⁸

4. *The First Amendment and the Refusal of Medical Treatment*

Assuming that a terminally ill patient can in fact force a

⁶⁰ *Id.* § 1 (7188, "Directive").

⁶¹ Subsection 7188.5 is a special provision for patients in a "skilled nursing facility." *Id.* § 1 (7188.5). The basis for this provision is that some patients in such facilities are so insulated from a voluntary decision-making role that special steps are required to assure that the patient is capable of willfully and voluntarily executing a directive. In order for such a patient validly to execute such a document, one of the witnesses signing the directive must be a patient advocate or ombudsman designated by the State Department of Aging. *Id.*

⁶² *Id.* § 1 (7189).

⁶³ *Id.* § 1 (7189.5).

⁶⁴ *Id.* § 1 (7194).

⁶⁵ *Id.*

⁶⁶ *Id.* § 1 (7190).

⁶⁷ *Id.* § 1 (7192(a)).

⁶⁸ *Id.* § 1 (7192(b)).

doctor to cease treating him, the doctor still may be able to secure a court order allowing the treatment based on the state's interest in preserving life. The cases on this subject usually arise in the context of a patient asserting his first amendment right to freedom of religion⁶⁹ against the physician's assertion that the state has an interest in preserving life.⁷⁰

The first amendment right to religious belief and the free exercise thereof is dual in nature: a person has the absolute right to hold any religious belief, however, he has only a qualified right to practice such belief, in that he may only practice it in a manner that does not violate the rights of others or contravene the public interest.⁷¹ For example, the state may prohibit the handling of poisonous snakes in religious ceremonies even though only the willing participants are in actual danger.⁷² The state may impose monetary fines on individuals who because of their religious beliefs refuse to be vaccinated for certain diseases.⁷³

*In re Osborne*⁷⁴ is a case in which a patient successfully asserted his right to freedom of religion in order to overcome an action by the hospital seeking a petition for appointment of a guardian to give consent to the administration of blood transfusions. In that case a member of the Jehovah's Witnesses faith refused the transfusions for religious reasons. The court found that the patient understood the consequences of his execution of a statement refusing the recommended transfusion and releasing the hospital from liability. The court narrowed the issues to two critical questions: "(1) has the patient validly and knowingly chosen this course for his life, and (2) is there compelling state interest which justifies overriding that

⁶⁹ "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . ." U.S. CONST. amend. I. This first amendment right is extended to the states by the fourteenth amendment. *Cantwell v. Conn.*, 310 U.S. 296, 303 (1940); *School Dist. of Abington Township v. Schempp*, 374 U.S. 203, 215 (1963).

⁷⁰ The court in the *Quinlan* case stated that the circumstances of that case did not reflect a first amendment freedom of religion question. 355 A.2d at 661.

⁷¹ *Lawson v. Commonwealth*, 164 S.W.2d 972 (Ky. 1942); *Annot.*, 9 A.L.R. 3d 1391, 1393 (1966).

⁷² *Hull v. State*, 88 So. 2d 880 (Ala. 1956); *Lawson v. Commonwealth*, 164 S.W.2d 972 (Ky. 1942).

⁷³ *Jacobson v. Mass.*, 197 U.S. 11 (1905).

⁷⁴ 294 A.2d 372 (D.C. 1972).

decision?"⁷⁵ The court answered the first question affirmatively. The second question was answered negatively because the patient's financial resources could provide for sufficient care for his two children in the event of his death.

The Illinois Supreme Court was faced with a similar situation in the case of *In re Estate of Brooks*.⁷⁶ The case arose as an appeal from a circuit court order appointing a conservator and authorizing him to consent to a blood transfusion. The patient had refused transfusions based on her religious beliefs and had signed a document relieving the physician and hospital from civil liability. Although the blood transfusion had been given, the conservator had been discharged, and the case was moot, the court decided to resolve the issue because of its importance. In holding that the decision of the circuit court was incorrect, Justice Underwood stated:

It seems to be clearly established that the First Amendment of the United States Constitution as extended to the individual States by the Fourteenth Amendment to that constitution, protects the absolute right of every individual to freedom in his religious belief and the exercise thereof, subject only to the qualification that the exercise thereof may properly be limited by governmental action where such exercise endangers, clearly and presently, the public health, welfare or morals. Those cases which have sustained governmental action as against the challenge that it violated the religious guarantees of the First Amendment have found the proscribed practice to be immediately deleterious to some phase of public welfare, health or morality. The decisions which have held the conduct complained of immune from proscription involve no such public injury and no danger thereof.⁷⁷

Finding no overriding danger to society in not granting the order to authorize the transfusion, the court criticized the decision of the lower court: "[W]hat has happened here involves a judicial attempt to decide what course of action is best for a particular individual, notwithstanding that individual's contrary views based upon religious convictions. Such action cannot be constitutionally countenanced."⁷⁸

⁷⁵ *Id.* at 375.

⁷⁶ 205 N.E.2d 435 (Ill. 1965).

⁷⁷ *Id.* at 441-42.

⁷⁸ *Id.* at 442.

In a number of cases the courts have been reluctant to refuse to grant orders authorizing the medical treatment. Freedom of religious belief has been outweighed by the state's interest in cases in which a parent refused to authorize a blood transfusion for a child.⁷⁹ The state's interest in maintaining the life of an unborn child has been held to override the pregnant mother's right to free exercise of religion,⁸⁰ and the state's interest in the welfare of dependent children has been held to override the rights of the parent.⁸¹ In each of these instances it was held that the state has a valid interest in the welfare of the child, although in at least one case, *In re Osborne*,⁸² this interest was not sufficient because the parent had provided for the care of the child in the event of his death.

The often-cited case *John F. Kennedy Memorial Hospital v. Heston*⁸³ held that the interests of the hospital and its staff, as well as the state's interest in life, warrant an order authorizing a blood transfusion despite the patient's refusal.⁸⁴ The court analogized the situation to that of a person attempting to commit suicide, pointing out that there is no constitutional right to die.⁸⁵

If the State may interrupt one mode of self-destruction [suicide], 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

⁷⁹ *Morrison v. State*, 252 S.W.2d 97 (Mo. 1952); *State v. Perricone*, 181 A.2d 751 (N.J. 1962), *cert. denied*, 371 U.S. 890 (1962).

⁸⁰ *Raleigh Fitken-Paul Morgan Memorial Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964), *cert. denied*, 377 U.S. 985 (1964). This decision was rendered before the companion abortion cases, *Roe v. Wade*, 410 U.S. 113 (1973) and *Doe v. Bolton*, 410 U.S. 179 (1973). It is not clear if those cases would change the *Anderson* holding.

⁸¹ *In re President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964).

⁸² 294 A.2d 372 (D.C. 1972).

⁸³ 279 A.2d 670 (N.J. 1971).

⁸⁴ Apparently the evidence was contradictory on whether the patient actually expressed a refusal of the transfusion. She was in shock when admitted to the hospital, and although she later testified that she had expressed her refusal, the attending physicians and nurses testified that she was incoherent upon admittance or soon thereafter. She executed no release to the hospital. *Id.* at 671. However, nothing in the language of the opinion indicates that the decision of the court was affected by this contradiction of the facts, or that the court would have held differently had it been clear that she did refuse the transfusion.

⁸⁵ *Id.* at 672.

medical option itself is laden with the 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.⁸⁶

The court went on to state that the interests of the physician and the hospital must also be considered.⁸⁷

In *In re President and Directors of Georgetown College, Inc.*,⁸⁸ Judge Skelly Wright upheld an order appointing a guardian with the power to authorize a blood transfusion for a member of the Jehovah's Witnesses faith who had lost two-thirds of her body's blood supply from a ruptured ulcer. The attending physicians determined that she had better than a 50 percent chance to live if the transfusion was administered, but without the transfusion death would be imminent. Finding that the patient was not *compos mentis* at the time consent was requested, Judge Wright decided that the appointment was justified. The patient had a 7-month old child, did not wish to die, and did not believe she would be religiously responsible if the transfusion was given without her consent. On the basis of these factors, the state had an interest sufficient to outweigh the exercise of the patient's first amendment rights.

In *United States v. George*⁸⁹ the court reviewed an order authorizing a blood transfusion. The court relied heavily on Judge Wright's opinion in *In re President and Directors of Georgetown College, Inc.*⁹⁰ and added a new factor to the usual set of interests which are sufficient to authorize transfusions:

[T]he doctor's conscience and professional oath must also be respected. In the present case the patient voluntarily submitted himself to and insisted upon medical care. Simultaneously he sought to dictate to treating physicians a course of treatment amounting to medical malpractice. To require these doctors to ignore the mandates of their own conscience, even in the name of free religious exercise, cannot be justified under these circumstances. The patient may knowingly decline treatment, but he may not demand mistreatment.⁹¹

⁸⁶ *Id.* at 673.

⁸⁷ *Id.* at 674.

⁸⁸ 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964).

⁸⁹ 239 F. Supp. 752 (D. Conn. 1965).

⁹⁰ 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964).

⁹¹ 239 F. Supp. at 754.

Though the interest of the physician should be considered, it alone is insufficient to override an individual's constitutional rights, since the physician's interest is not a valid state interest.⁹² In all cases in which this interest was mentioned, other valid state interests were present to override the individual's constitutional rights. The discussion of the physician's interests in those cases is no more than dicta strengthening the court's position.

The impact of these decisions is that the right to die based on freedom of religion is very limited. First, the patient must have a sincere belief that his religion condemns the treatment even if it is forced upon him.⁹³ Secondly, the cases which allow refusal are limited to those situations in which the state's interest is not sufficient to overcome the individual's constitutional rights.⁹⁴

B. *Guardianship*

It is apparent from the discussion of the doctor-patient relationship and the refusal of medical treatment based on freedom of religion that situations will arise where the patient is incapable of making his own decisions on the refusal of medical treatment. This could occur any time a person unexpectedly becomes mentally incapacitated. The issue that arises in such situations is whether a guardian may assert the refusal of treatment for the incapacitated party.

The appointment of guardians is usually governed by stat-

⁹² It should be noted that in *United States v. George* the patient had a dependent child, giving the state an interest in the patient's life.

⁹³ The court in *In re Osborne*, 294 A.2d 372 (D.C. 1972), appeared to be impressed with the fact that the patient believed he would not be allowed to enter the "Bible's promised new world" if he received a transfusion, even if that transfusion was forced upon him against his will. Compare that case with *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965), in which the court ordered the transfusion. There the court pointed out that the patient stated his conscience would be clear if the transfusion was forced upon him and that he would not resist the doctor's action if the court order was signed. It appears from these cases that to refuse the transfusion successfully the patient must have a strong religious conviction against receiving it.

⁹⁴ One case indicated the possibility of bringing an action under the Civil Rights Act, 42 U.S.C. § 1983 (1871) for treating a patient in a manner inconsistent with his religious beliefs under color of state law when there is no compelling state interest to allow such a violation. *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972).

ute. Statutes vary in appointment procedures and powers conferred on the guardian.

In many states, the statutes authorize the appointment of a guardian of the person, a guardian of property, or a guardian of both. Unless otherwise specified, a person is guardian of both the person and the property of his ward. Different persons may be appointed as guardians of the person and of the property although this should be done only in exceptional cases. In some states the statutes only authorize the appointment of a guardian without distinguishing between guardians of a person and guardians of the property.⁹⁵

In most statutes dealing with guardianship, the power of the guardian does not extend to extraordinary powers such as terminating the life of an incompetent patient. Therefore, where the scope of the guardianship statute is inadequate, the substituted judgment doctrine has been utilized. The substituted judgment doctrine allows the court to act as the incompetent's supreme guardian by exercising its equitable powers.

Those jurisdictions which have extended the substituted judgment rule to personal affairs of the incompetent have done so on the ground that it was in the incompetent's "best interest." The substituted judgment doctrine's extension to the personal affairs of incompetents has developed through a series of organ transplant cases. In 1941, the District of Columbia Circuit Court of Appeals in *Bonner v. Moran*⁹⁶ implied that "where consent is obtained from the child's parent, an operation on the infant for the benefit of another may be performed."⁹⁷ In three unreported Massachusetts cases in 1957⁹⁸ the court was confronted with the problem of whether to allow a kidney transplant to one suffering from kidney disease from his healthy identical twin.⁹⁹ In all three of these Massachusetts cases, the

⁹⁵ Fraser, *Guardianship of the Person*, 45 IOWA L. REV. 239 (1960).

⁹⁶ 126 F.2d 121 (D.C. Cir. 1941). This case dealt with the issue of whether a 15-year-old boy could consent to a skin graft.

⁹⁷ *Id.* at 123. See also Comment, *Surgical Transplants—Permission for Performing a Kidney Transplant Denied as Against Incompetent Donor's Best Interest—In re Richardson*, 5 CUM.-SAM. L. REV. 163, 166 (1975).

⁹⁸ *Foster v. Harrison*, No. 68674 Eq. (Mass. Sup. Jud. Ct. Nov. 20, 1957); *Huskey v. Harrison*, No. 68666 Eq. (Mass. Sup. Jud. Ct. Aug. 30, 1957); *Masden v. Harrison*, No. 68651 Eq. (Mass. Sup. Jud. Ct. June 12, 1957).

⁹⁹ *Savage, Organ Transplantation with an Incompetent Donor: Kentucky Re-*

court analyzed the following factors in determining whether to allow the transplant:

1. The parents must consent as in any medical procedure on a minor;
2. The minor donor must understand the consequences of his donation, and give his informed consent, even though technically, by itself, such consent has no legal validity; and,
3. The transplant must benefit the donor.¹⁰⁰

The Massachusetts court emphasized the "benefit" to the donor as supported by psychiatric testimony.

The case most often cited for extension of the doctrine of substituted judgment to an incompetent's personal affairs is *Strunk v. Strunk*.¹⁰¹ In *Strunk* the Kentucky Court of Appeals was confronted with the question of whether the court could properly exercise its equity power to authorize a kidney transplant, parental consent not being a factor.¹⁰² In this case a 28-year-old brother had a fatal kidney disease which necessitated a kidney transplant. A 26-year-old brother, who was mentally ill and legally incompetent, had no objection to serving as a donor for the transplant, and the parents were in favor of the transplant and consented on behalf of the incompetent. The hospital, however, refused to honor the guardian's consent since it went beyond the usual powers of a guardian, and requested that the guardian obtain some type of court order authorizing the transplant. The plaintiffs argued that the court had jurisdiction and authority to allow a transplant which would be psychologically beneficial to the incompetent donor.¹⁰³ Furthermore, the plaintiffs argued that by denying his request the court would be compromising his constitutional rights of due process, equal protection, and security of his person.¹⁰⁴ The Court of Appeals recognized that this was the first

solves the Dilemma of Strunk v. Strunk, 58 Ky. L.J. 129 (1970). See also Curran, *A Problem of Consent: Kidney Transplantation in Minors*, 34 N.Y.U.L. REV. 891, 892 (1954); Stetter, *Kidney Donation from Minors and Incompetents*, 35 LA. L. REV. 551 (1975); and Comment, *Anatomical Transplants: Legal Developments in Wisconsin*, 59 MARQ. L. REV. 605 (1976).

¹⁰⁰ Savage, *supra* note 99, at 136.

¹⁰¹ 445 S.W.2d 145 (Ky. 1969). See also Comment, *supra* note 97, at 163, 166.

¹⁰² 445 S.W.2d at 145.

¹⁰³ *Id.* at 146-47.

¹⁰⁴ *Id.* at 147.

reported case dealing directly with the issue.¹⁰⁵ In discussing the Kentucky guardian statute the Court stated: "Review of our case law leads us to believe that the power given to a committee under KRS 387.230 would not extend so far as to allow a committee to subject his ward to the serious surgical techniques thereunder consideration unless the life of his ward be in jeopardy."¹⁰⁶ Even though the Court did not allow use of the guardianship statute, it did recognize the applicability of the doctrine of substituted judgment. The Court said that in light of the fact that the transplant would benefit the donor, it would exercise its authority to substitute its judgment for the benefit of such persons who are incapable of protecting themselves.¹⁰⁷ There was testimony to the effect that had the incompetent's brother died as a result of the kidney disease, his death would have had a tremendous psychological impact on the incompetent.¹⁰⁸ The *Strunk* Court decided four to three in favor of the transplant; the minority based their dissent on the majority's finding that the transplant would "benefit" the incompetent donor.¹⁰⁹

One authority claims there are two possible ways to interpret the *Strunk* holding:

In its narrowest construction, *Strunk* holds that a person incapable of understanding the procedures may donate a part of his body for transplantation. This is the first reported case so holding in the United States. The decision will obviously have an impact on future cases involving transplants from incompetents or minors too young to understand or consent.

¹⁰⁵ *Id.* at 149.

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* See generally Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976); Comment, *Kidney Transplant—Mentally Incompetent Donor*, 35 MO. L. REV. 538 (1970).

¹⁰⁸ 445 S.W.2d at 146.

¹⁰⁹ *Id.* at 150. See also Comment, *Spare Parts from Incompetents: A Problem of Consent*, 9 J. OF FAMILY L. 309 (1969); Comment, *Transplantation—Incompetent Donors: Was the First Step or the Last Step Taken in Strunk v. Strunk?*, 58 CAL. L. REV. 754 (1970).

An absolute prohibition would obviate the abuses likely to result if parental consent is deemed sufficient as well as those likely to attend judicial authorization The fact that the probable dangers are much less serious than they potentially could be, or have been, and the little expanded opinions of emotional trauma which have thus far appeared, seem to be frail reasons for not erring on the safe side to avoid the danger completely.

Id. at 775.

In its broadest construction, *Strunk* holds that a court of equity has the enormous power to make whatever orders it may deem necessary for the benefit of those not capable of looking after themselves. The case is the most recent and probably the most dramatic example of the doctrine of substituted judgment in this country. I think it is this latter construction that frightened the dissenting judges.¹¹⁰

The Court in *Strunk* was impressed by the fact that all members of the incompetent's family requested the transplant.¹¹¹ Thus, *Strunk v. Strunk* is important case law today in that it was the first case in which a court through *written* opinion exercised its equitable power of substituted judgment to allow an organ transplant.

Two organ transplant cases decided after the *Strunk* decision adopted the substituted judgment doctrine as applied by the Kentucky Court of Appeals. In *Howard v. Fulton-DeKalb Hospital Authorities*¹¹² the Georgia Superior Court permitted a kidney transplant from a mentally retarded donor on the ground that it would benefit the incompetent. In applying the doctrine of substituted judgment, the court "determined that the retarded child would be substantially benefited by permitting her to donate a kidney to her ailing mother."¹¹³ In *Hart v. Brown*¹¹⁴ the Connecticut Superior Court also adopted the substituted judgment doctrine in allowing a kidney transplant. The court, however, did not emphasize benefit to the minor donor. Instead the court stressed the potential benefit to the *afflicted* twin by a kidney transplant and the presence of parental consent. "The *Hart* decision is unique in that the best interest of the minor as donor was not an important factor in the authorization of the transplant."¹¹⁵

The generosity of courts in allowing organ transplants from incompetent donors was attacked by the Louisiana Court of Appeals in 1973 in the case of *In re Richardson*.¹¹⁶ In *Richardson*

¹¹⁰ Savage, *supra* note 99, at 155.

¹¹¹ 445 S.W.2d at 147.

¹¹² 42 U.S.L.W. 2322 (Ga. 1973).

¹¹³ Comment, *supra* note 97, at 163.

¹¹⁴ 289 A.2d 386 (Conn. 1972).

¹¹⁵ Comment, *supra* note 97, at 167.

¹¹⁶ 284 So. 2d 185 (La. 1973).

the court said that since the donor was an incompetent and the transplant was not for his immediate benefit, the court's permission was necessary to proceed with the operation.

Surgical operations for the immediate benefit of the child must be distinguished from operations upon a child for the benefit of another person. To perform an operation where the child receives physical benefit, parental consent is sufficient. However, the issue of whether parental consent is sufficient in an operation for the benefit of another has not yet been conclusively settled.¹¹⁷

The court went on to state that it did not have equitable authority to permit the transplant when it was not for the donor's benefit.¹¹⁸ A similar result was reached by the Supreme Court of Wisconsin in *In re Guardianship of Pescinski*.¹¹⁹ The court, noting that a guardian must act in the best interest of his ward, stated that there was absolutely no evidence that any interest of the ward would be served by the transplant.¹²⁰ The opinion went on to reject the substituted judgment doctrine adopted by *Strunk*.

This review of the case law dealing with organ transplants from incompetent donors indicates that the courts disagree on when an incompetent will be permitted to serve as a donor for an organ transplant. In *Strunk* and *Hart* the courts emphasized the benefit to the incompetent and applied the substituted judgment doctrine. In *Richardson* and *Pescinski* the courts either failed to find a benefit to the incompetent donor or flatly rejected the substituted judgment doctrine. It is important to note, however, that none of these decisions gave the guardian absolute authority to consent to the organ transplant when the ward was the donor and not the donee. More important, however, is the fact that the cases dealing with the guardian's role in consenting to organ transplants can be analogized to cases in which a guardian asserts an incompetent's right to refuse extraordinary life-sustaining procedures.

¹¹⁷ Comment, *supra* note 97, at 163, 165.

¹¹⁸ 284 So. 2d 185, 187 (La. 1973). *But cf.* Comment, *supra* note 97, at 163, 167-68.

¹¹⁹ 226 N.W.2d 180 (Wis. 1975).

¹²⁰ *Id.* at 181.

C. *Euthanasia and the Criminal Law*

A contention that passive or active euthanasia is legally acceptable will be met with forceful rebuttal that any such act is suicide or murder, which are, of course, against the public interest.¹²¹ One must consider, however, whether the acts involved are technically murder or suicide, and if so, whether the interests served by making those acts illegal are served by making euthanasia illegal.

Criminal law distinguishes a commission from an omission. An individual is not guilty of a criminal offense unless he has engaged in conduct which includes a voluntary act or involves an omission to perform a duty which the law imposes upon him.¹²² Since liability for an omission is based upon a duty to act and a failure to act, if a conscious patient refuses medical treatment and the physician does not administer treatment, the doctor cannot be held criminally liable for the failure to act because no duty is present.¹²³

The issue becomes more complicated in the situation in which treatment is withdrawn or a life-sustaining machine is turned off. The question then is whether the withdrawal of medical treatment is a commission (an overt action of withdrawing medication or turning off a life-sustaining machine) or an omission (the failure to provide medication or the failure to allow a life-sustaining machine to continue to maintain the patient's vital functions). If the withdrawal is an omission, and the physician has no duty to act because the patient has withdrawn consent, then clearly the physician is not criminally

¹²¹ Suicide was a criminal offense at common law. *Commonwealth v. Hicks*, 82 S.W. 264, 266 (Ky. 1904); Kutner, *supra* note 14, at 543. "To the extent anti-suicide laws remain on the books, they are directed toward authorizing officials to take temporary custody of the individual to prevent the immediate infliction of harm and to render psychological assistance." CURRAN & SHAPIRO, *LAW, MEDICINE AND FORENSIC SCIENCE* 832 (1970), *cited in* Cantor, *supra* note 14, at 246.

¹²² MODEL PENAL CODE § 2.01(1), (3) (Proposed Official Draft, 1962), KRS § 501.030(1) (1974).

¹²³ Authorities have failed to find a case addressing the question of whether a physician who fails to take positive steps to prolong the life of a dying patient is guilty of homicide. Gurney, *Is There a Right to Die? - A Study of the Law of Euthanasia*, 3 CUM. SAM. L. REV. 235, 248 (1972), *cited in* *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 3, at 1207; Kasimer, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 982 n.41 (1958); Silving, *supra* note 6, at 360.

liable. On the other hand, if the withdrawal is a commission, criminal prosecution is possible.

Moving further along the continuum from conduct which would clearly be an omission through the gray area in which the conduct could be classified as an omission or a commission, one reaches conduct which is clearly a commission. This category would include actions such as administering a drug to the patient that hastens death.¹²⁴ Although juries are reluctant to find a person guilty of such an action when the victim is a terminally-ill patient,¹²⁵ the defendant is clearly subject to criminal prosecution.

The conclusion is that if treatment is never given to the dying patient, and the physician is under no duty to provide treatment since the patient never gave his consent, the doctor is not guilty of a criminal act if his behavior is classified as an omission. If the doctor administers drugs that hasten death, he is clearly guilty of homicide regardless of the absence of a duty. The liability of the doctor is not clear if the conduct is between these two extremes.

II. IN RE QUINLAN

A. *The Facts*

Karen Ann Quinlan was born on March 29, 1954.¹²⁶ On the night of April 15, 1975, "for reasons still unclear,"¹²⁷ Karen apparently ceased breathing for at least two 15-minute periods.¹²⁸ On Karen's admission to nearby Newton Memorial Hos-

¹²⁴ Two doctors in this country have been charged with first degree murder for such conduct. Both were acquitted. See text accompanying notes 12-23 *supra*.

¹²⁵ See note 19 *supra*.

¹²⁶ See note 19 *supra*.

¹²⁷ *In re Quinlan*, 348 A.2d 801, 806 (N.J. Super. 1975). Karen is the adopted daughter of Joseph and Julia Quinlan and one of three children. See *IN THE MATTER OF KAREN QUINLAN I* [hereinafter cited as *QUINLAN I*], Plaintiff's Complaint at 2. Karen was baptized and reared in the Roman Catholic Church and attended elementary and secondary schools affiliated with the Roman Catholic Church. Sometime in late 1974 or early 1975, Karen moved from her parent's home in Landing, New Jersey, and "had at least two subsequent residences with the last being a lake cottage in Sussex County, New Jersey." 348 A.2d at 806.

¹²⁸ 355 A.2d at 653.

¹²⁹ 348 A.2d at 806. The exact length of time she was without spontaneous respiration is unknown. *Id.* Mouth-to-mouth resuscitation was initially applied by friends at

pital, her condition was described as a "coma of unknown etiology."¹²⁹ Urine and blood tests "indicated the presence of quinine, aspirin, barbituates . . . and traces of valium and lithium."¹³⁰ Karen was unable to breathe spontaneously or independently and required a respirator for assistance.¹³¹ Upon review of the medical records, one of the attending physicians indicated that the drugs found by the blood and urine tests were within "therapeutic range" and the quinine discovered was consistent with that used in mixed drinks.¹³²

While the cause of the unconsciousness and periodic cessation of respiration remains undetermined, Karen's comatose condition was apparently caused by "anoxia," an insufficient supply of oxygen in the blood.¹³³ On April 25, 1975, when Karen was transferred to nearby Saint Clare's Hospital, "she was still unconscious, still on a respirator and a tracheotomy had been performed."¹³⁴ Upon arrival at St. Clare's, Karen was admitted to the Intensive Care Unit where she was placed on an MA-1 respirator.¹³⁵

Karen's residence until an ambulance moved her to Newton Memorial Hospital. 355 A.2d at 654.

¹²⁹ QUINLAN I, *supra* note 126, Brief for Guardian ad Litem, at 53. The history "was essentially incomplete and uninformative." 355 A.2d at 654. Karen was observed to have normal vital signs, a temperature of 100 degrees, unreactive pupils, unresponsiveness to deep pain, a low blood oxygen level, and her legs in a rigid curled position, 348 A.2d at 806-07.

¹³⁰ 348 A.2d at 806.

¹³¹ *Id.* at 807.

¹³² *Id.* at 806.

¹³³ *Id.*

¹³⁴ 355 A.2d at 654.

¹³⁵ 348 A.2d at 807. The MA-1 respirator is designed to ensure that a controlled volume of air passes into the lungs and will completely take over the breathing function should the patient cease to breathe spontaneously. *Id.* Some 300 tests were performed to determine the basis for Karen's condition, including an electroencephalogram (EEG), a brain scan, an angiogram, and a lumbar puncture. 355 A.2d at 654. The brain scan, angiogram, and lumbar puncture were all normal in result; however, the electroencephalogram indicated an abnormal electrical rhythm of the brain, which one of the physicians indicated to be "consistent with her clinical state." QUINLAN I, *supra* note 126, Trial Record at 218. Dr. Morse indicated that Karen was originally in a sleep-like unresponsive condition which subsequently developed into a "sleep-wake cycle," a normal improvement for a patient in a comatose state. *Id.* at 222. Dr. Morse described the cycles as follows:

[W]hen Karen was originally seen, she was more in a condition like sleep-like unresponsiveness. When I transferred her to St. Clare's she was in that same condition. But as time came on, she switched from a position—she

Upon learning of Karen's condition, the Quinlan family hoped for improvement though the doctors appeared pessimistic.¹³⁶ Karen's parents visited her bedside twice daily¹³⁷ and had

developed what we call sleep-wake cycles. Now a person can have these sleep-wake cycles and still be in a coma. Again, "coma" is the lack of consciousness. So you can be awake and still be unresponsive to your environment.

. . . .

I mean she has her eyes open. She blinks, and things of that sort, which is the arousability factor of the coma. But a person—if you and I and the other attorneys were standing there, it is my impression, and even the attending doctors', from watching her on a daily basis and even feeding her, that a rudimentary supportive mechanism such as getting your food—when you go to the zoo, the animals will come over to you by instinct. Karen doesn't even follow the act of hanging the IV bottle up to get her food, and to me—many other things that we have observed, on an ongoing basis you know—

Id.

Although Karen has been observed to blink or cry out during the awake cycle, she is still unconscious and "totally unaware of anyone and anything around her." 355 A.2d at 654. The daily chart maintained by a 24-hour nursing staff indicated the following record as it pertained to Karen's "vital signs":

1. Her color was generally pale, her skin warm; she was almost constantly suffering from diaphoresis (sweating), many times profusely but occasionally moderately or not at all;
2. There was always a reaction to painful stimuli, she responded decerebrately to pain, she sometimes would grimace as if in pain, which would be followed by increased rigidity of her arms and legs;
3. There would be periodic contractions and spasms, periodic yawning, periodic movements of spastic nature;
4. Pupils were sometimes dilated, sometimes normal, but almost always sluggish to light;
5. Body waste disposal through the urethral catheter and the bowel was indicated to occur;
6. Feedings of Vivinex were given alternately with water on various nurses [*sic*] shifts;
7. The nurses were constantly moving, positioning and bathing her;
8. Body rashes occurred at times; decubiti were treated with heat lamps on occasions;
9. Sometimes she would trigger and assist the respirator; other times she would go for periods without triggering it at all;
10. Her extremities remained rigid with contraction of them being described as severe at times;
11. On May 7 nurses indicated she blinked her eyes two times when asked to and appeared responsive by moving her eyes when talked to, but there is no further evidence of this type reaction thereafter.

348 A.2d at 808-09.

¹³⁶ COLEN, *supra* note 2, at 31. Joseph Quinlan testified that Dr. Morse had continuously told the family not to get their hopes up and that Dr. Morse had stated that even if by some miracle Karen should survive, he would never take her home; she would

frequent conferences with Dr. Morse, Karen's attending physician, and Dr. Arshad Javed, the attending pulmonary internist who assisted Dr. Morse. Karen's condition deteriorated during the months following her admission to the hospital and she suffered a weight loss of over 40 pounds.¹³⁸ Attempts to wean Karen from the respirator were unsuccessful.¹³⁹ As the months passed without encouragement of recovery or even improvement, the Quinlan family entertained the proposition that Karen should be disconnected from the MA-1 respirator and allowed a natural death. The decision by the family to allow Karen to die was not made until July 1975, some 3 months following Karen's hospitalization.¹⁴⁰ The Quinlan family sought and received the support of their priest in the decision.¹⁴¹ In a series of meetings attended by the Quinlans, Drs. Morse and Javed, and the hospital officials, the Quinlans said they were led to believe that their request would be granted "if a precedent could be found for doing so."¹⁴² The hospital and doctors then changed their minds, requiring the Quinlans to present a written release before any action would be taken to discontinue the use of the respirator.¹⁴³ On July 31, 1975, the Quinlans signed a written consent authorizing the discontinuance of all

spend the remainder of her life in an institution. QUINLAN I, *supra* note 126, Trial Record at 361.

¹³⁷ COLEN, *supra* note 2, at 31.

¹³⁸ 355 A.2d at 655.

¹³⁹ *Id.*

¹⁴⁰ QUINLAN I, *supra* note 126, Trial Record at 362. As Joseph Quinlan explained at trial, the other members of the family had already arrived at their decision to allow Karen to die naturally when he finally reached his decision. COLEN, *supra* note 2, at 31. Joseph Quinlan swore under oath in court that it was Dr. Javed, the pulmonary internist, who first suggested withdrawing the use of the respirator. *Id.* at 34. Dr. Javed, however, "swore under oath that he had only suggested an attempt be made to 'wean' Karen off the machine." *Id.*

¹⁴¹ To confirm the moral rightness of the decision he was about to make he consulted with his parish priest and later with the Catholic chaplain at St. Clare's Hospital. He would not, he testified, have sought termination [of the machine] if that act were to be morally wrong or in conflict with the tenets of the religion he so profoundly respects. He was disabused of doubt, however, when the position of the Roman Catholic Church was made known to him as it is reflected in the record of this case.

355 A.2d at 658.

¹⁴² COLEN, *supra* note 2, at 35.

¹⁴³ *Id.*

extraordinary measures¹⁴⁴ and releasing the physicians and the hospital "from any and all liability."¹⁴⁵ The Quinlans went home that night resolved that the machine would be removed the next day.¹⁴⁶ The doctors and the hospital again had a change of heart and stated that notwithstanding the release, they would not withdraw the respirator.¹⁴⁷ Dr. Morse testified that "[a]fter checking on other medical case histories he concluded that to terminate the respirator would be a substantial deviation from medical tradition, that it involved ascertaining 'quality of life', and that he would not do so."¹⁴⁸ At this point, Drs. Morse and Javed, along with the hospital, stated that they would terminate the use of the respirator only if the Quinlans could have themselves appointed as Karen's guardians.¹⁴⁹ To comply with this requirement, the Quinlans were forced to seek the approval of the judiciary through a guardianship proceeding.

On September 10, 1975, Joseph Quinlan filed in the Superior Court of New Jersey a petition requesting that Karen be adjudged mentally incompetent and that he be appointed Karen's guardian "with the express power of authorizing the discontinuance of all extraordinary means of sustaintaing the vital processes of his daughter"¹⁵⁰ In response to Joseph Quinlan's petition, Judge Robert Muir appointed Daniel Coburn as Guardian ad Litem of Karen to represent her in the action.¹⁵¹ On September 16, 1975, Joseph Quinlan filed a supplemental complaint which reiterated his earlier petition and

¹⁴⁴ 348 A.2d at 813-14. The contents of the release signed by the Quinlans is as follows:

We authorize and direct Doctor Morse to discontinue all extraordinary measures, including the use of a respirator for our daughter Karen Quinlan.

We acknowledge that the above named physician has thoroughly discussed the above with us and that the consequences have been fully explained to us. Therefore, we hereby RELEASE from any and all liability the above named physician, associates and assistants of his choice, Saint Clare's Hospital and its agents and employees.

Id.

¹⁴⁵ *Id.*

¹⁴⁶ QUINLAN I, *supra* note 126, Trial Record at 364.

¹⁴⁷ COLEN, *supra* note 2, at 35.

¹⁴⁸ 348 A.2d at 814.

¹⁴⁹ COLEN, *supra* note 2, at 35.

¹⁵⁰ QUINLAN I, *supra* note 126, Plaintiff's Complaint at 3.

¹⁵¹ QUINLAN I, *supra* note 126, Order Appointing Guardian ad Litem at 11.

additionally sought to have the court permanently enjoin the Morris County prosecutor "from interference with or criminal prosecution arising out of any relief" granted by the court.¹⁵² The supplemental complaint also requested that the court permanently enjoin Dr. Morse, Dr. Javed and St. Clare's Hospital from interference with any relief granted by the court.¹⁵³ Judge Muir ordered the Morris County Prosecutor, Donald Collester, Jr., Dr. Morse, Dr. Javed, and St. Clare's Hospital to show cause why an order sustaining Joseph Quinlan's complaint should not be entered. On September 22, 1975, after the prosecutor, physicians, and hospital presented arguments to the court against the granting of the relief sought by Joseph Quinlan, Judge Muir set October 20, 1975, as the trial date.

Trial briefs were submitted by all parties involved in the litigation. Counsel for Joseph Quinlan contended that the "courts of New Jersey and other jurisdictions have not hesitated to decide cases challenging the administration of life-sustaining medical treatment" and that the court is empowered through a declaratory judgment action to appoint a guardian for the incompetent.¹⁵⁴ The petitioners further argued that denial of the relief sought would violate the constitutionally protected rights of Karen and her family.¹⁵⁵ The petitioners argued that denial of the relief sought would interfere with the free exercise of the Quinlan's religious beliefs as protected by the first amendment and would constitute imposition of "cruel and unusual punishment" which is prohibited by the eighth amendment.¹⁵⁶ The petitioners did reverse their position that Karen was legally dead.¹⁵⁷ Briefs were also submitted by the Guardian ad Litem, the New Jersey Attorney General, counsel for Drs. Morse and Javed, the Morris County Prosecutor, and St. Clare's Hospital.¹⁵⁸ In general, the briefs submitted by the

¹⁵² QUINLAN I, *supra* note 126, Plaintiff's Supplemental Complaint at 14.

¹⁵³ *Id.*

¹⁵⁴ QUINLAN I, *supra* note 126, Brief for Plaintiff at 36.

¹⁵⁵ *Id.* at 43.

¹⁵⁶ *Id.* at 43, 48.

¹⁵⁷ *Id.* at 50. Joseph Quinlan initially asserted that Karen was legally dead; however, this contention was dropped at the pretrial conference. 355 A.2d at 652.

¹⁵⁸ The Attorney General of New Jersey intervened in the litigation as a matter of right pursuant to R. 4:33-1 on behalf of the State of New Jersey. 355 A.2d at 651.

opponents to Joseph Quinlan's petition presented the following arguments:

1. Even though the court has jurisdiction to appoint Joseph Quinlan as permanent guardian for Karen, the court should appoint someone other than Joseph Quinlan;¹⁵⁹
2. Since there is no support in the law which entitles the plaintiffs to the relief sought when the incompetent is alive, the complaint should be dismissed as a matter of law since it is undisputed that Karen is not legally dead;¹⁶⁰
3. The relief sought by the petitioners violates the homicide laws of New Jersey;¹⁶¹ and
4. The denial of the relief sought by the petitioners would not be in violation of Karen's constitutionally protected right of free exercise of religion, right of privacy, and the right against imposition of cruel and unusual punishment.¹⁶²

The New Jersey Attorney General specifically argued that the court should not enjoin a hypothetical prosecution.¹⁶³ Counsel representing St. Clare's Hospital argued that "in the event that the relief sought by the plaintiff is granted, neither the hospital nor its employees, nor the doctors should be directed to discontinue the respirator."¹⁶⁴ Thus, from the arguments developed by the trial briefs, it appeared there would be a constitutional confrontation.

B. *The Trial Court's Holding*

The trial began on October 20, 1975, and concluded 7 days later.¹⁶⁵ On November 10, 1975, Judge Muir rendered his writ-

¹⁵⁹ See generally QUINLAN I, *supra* note 126, Brief on Behalf of Guardian ad Litem at 52, Brief on Behalf of Attorney General of New Jersey at 80, and Brief on Behalf of Dr. Arshad Javed and Dr. Robert J. Morse at 117.

¹⁶⁰ See generally QUINLAN I, *supra* note 126, Brief on Behalf of Guardian ad Litem at 52, Brief on Behalf of the Attorney General of New Jersey at 80, and Brief on Behalf of the Morris County Prosecutor at 155.

¹⁶¹ See generally QUINLAN I, *supra* note 126, Brief on Behalf of the Morris County Prosecutor at 151.

¹⁶² See generally QUINLAN I, *supra* note 126, Brief on Behalf of the Guardian ad Litem at 52.

¹⁶³ QUINLAN I, *supra* note 126, Brief on Behalf of the Attorney General of New Jersey at 80.

¹⁶⁴ QUINLAN I, *supra* note 126, Brief on Behalf of St. Clare's Hospital at 178.

¹⁶⁵ During the course of the trial, the court heard the testimony of Joseph and Julia Quinlan and their daughter, Mary Ellen. In addition to the testimony of Drs. Morse

ten opinion. The opinion first dealt with the plaintiffs' contention that the court had "the inherent power of an equity court" to act as protector and guardian of all persons under a disability.¹⁶⁶ The court responded by stating:

The breadth of the power to act and protect Karen's interest is, I conclude, controlled by a judicial conscience and morality which dictate the determination whether or not Karen Ann Quinlan be removed from the respirator is to be left to the treating physician. It is a medical decision, not a judicial one. I am satisfied that it may be concurred in by the parents but not governed by them. This is so because there is always the dilemma of whether it is the conscious being's relief or the unconscious being's welfare that governs the parental motivation.¹⁶⁷

The court went further to state that the court has power over a person suffering from a disability to protect and *aid* his best interests. Judge Muir declared that "[t]he single most important temporal quality Karen Ann Quinlan has is life."¹⁶⁸ The court concluded that it would not authorize the taking of Karen's life. The court noted that an equity court cannot supersede or abrogate positive statutory law.¹⁶⁹ Although New Jersey's homicide laws are based on common law principles, the court stated that decisions from other jurisdictions which have codified the common law are "dispositive of the manner in which this State would treat like circumstances."¹⁷⁰

and Javed, five other physicians were called upon for medical testimony. Father Thomas J. Trapasso, the Quinlan's priest and close friend, testified that the Roman Catholic Church would not disapprove of the judicial relief sought by the Quinlans. QUINLAN I, *supra* note 126, Trial Record at 395-96. The plaintiffs also called Father Pascal Caccavale, the chaplain of St. Clare's Hospital, to testify as to the Roman Catholic Church's position on the discontinuance of extraordinary medical means when the "patient has reached a point beyond medical knowledge to effectively help this person." *Id.* at 413. The court also heard from Lori Gaffney, a good friend of Karen's who testified that Karen had once said to her that "she would not want to be kept alive by machines, under any circumstances." *Id.* at 448.

¹⁶⁶ 348 A.2d at 816.

¹⁶⁷ *Id.* at 819. The language used by Judge Muir is unfortunate in that it is difficult to interpret the meaning of "judicial conscience." In the next sentence in the opinion, the court expressly declares that the decision is of a medical rather than a judicial nature. Thus, one can only speculate that Judge Muir meant the exercise of discretion where he wrote "judicial conscience."

¹⁶⁸ *Id.* at 820.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

The court declined the hospital's request for determination of whether the use of the definition of clinical death developed by the Harvard Medical School in 1968 is in accordance with "ordinary and standard medical practice."¹⁷¹ The court avoided this question by stating that "[w]hether Karen Quinlan one day becomes brain-dead and therefore should be removed from the respirator is a decision that will have to be based upon the extant ordinary medical criteria at the time."¹⁷²

The Superior Court next dealt with the constitutional issues raised by the plaintiffs. As to the right of privacy argument developed in *Griswold v. Connecticut*,¹⁷³ the court explained:

It is not significant to this opinion whether the right of self-determination is within the scope of the right of privacy. What is significant is the extent to which it is subject to a compelling state interest . . . and whether the right can be exercised by the parent for his child.¹⁷⁴

The court stated that "[t]he compelling state interest found lacking in *Wade, Baird, Griswold* and *Stanley* is"¹⁷⁵ present in this situation, in that the state has an "interest in preservation of life and the extension of the court's protection to an incompetent."¹⁷⁶ The court further declared "[t]here is no constitutional right to die that can be asserted by a parent for his incompetent adult child."¹⁷⁷ As to the plaintiffs' argument that the right to die is a religious belief protected by the Free Exercise Clause, the court responded by stating that although "[r]eligious beliefs are absolute under the Free Exercise Clause, [the] practice in pursuit thereof is not free from gov-

¹⁷¹ *Id.* at 820-21. Both the treating physicians and St. Clare's Hospital, in claiming Karen was not brain-dead, referred to the Ad Hoc Committee of Harvard Medical School report on brain death. The criteria established by the report are set out in *Report of the Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death: A Definition of "Irreversible Coma,"* 205 J.A.M.A. 337 (1968).

¹⁷² 348 A.2d at 821.

¹⁷³ 381 U.S. 479 (1965).

¹⁷⁴ 348 A.2d at 821.

¹⁷⁵ *Id.* at 822. See generally *Roe v. Wade*, 410 U.S. 113 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Stanley v. Ga.*, 394 U.S. 557 (1969); *Griswold v. Conn.*, 381 U.S. 479 (1965).

¹⁷⁶ 348 A.2d at 822.

¹⁷⁷ *Id.*

ernmental regulation.”¹⁷⁸ The court distinguished a line of cases which upheld parental standing to assert religious beliefs, stating that those cases dealt with the “future life conduct of their children, not the ending of life.”¹⁷⁹ Judge Muir summarily disposed of the plaintiffs’ claim that the use of futile extraordinary measures constituted “cruel and unusual punishment” by declaring that the eighth amendment is not applicable to civil actions.¹⁸⁰

In evaluating the evidence and law presented, the court held that the questions surrounding the care and treatment of Karen were medical in nature and should be resolved by physicians, not the courts. The court did recognize that there would be instances “relating to further treatment that will require a guardian’s counsel, advice and concurrence.”¹⁸¹ Judge Muir stated that although there was no reason why Joseph Quinlan should not serve as guardian, Mr. Quinlan would not be appointed in order to avoid burdening him with the anguish of day-by-day decisions as to future care and treatment of his daughter.¹⁸² The court accordingly appointed an independent guardian. Clearly the trial court recognized no right to die. Some believe that Judge Muir “should have . . . end[ed] the matter by ruling that the questions involved were such that they should have been settled by the Quinlans and Karen’s physicians,” without being forced into a trial situation.¹⁸³

C. *The Appellate Court’s Holding*

The Quinlans appealed to the New Jersey Supreme Court,¹⁸⁴ which affirmed the trial court as to the contention that the Free Exercise Clause¹⁸⁵ and the Cruel and Unusual

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 823.

¹⁸⁰ *Id.* at 823-24.

¹⁸¹ *Id.* at 824.

¹⁸² *Id.*

¹⁸³ COLEN, *supra* note 2, at 54. Although the court did decide on the constitutionality of one’s right to die, the decision “set off a wave of confusion and near panic among those who practice emergency medicine by declaring that decisions to end life-sustaining treatment are medical decisions, but a physician who makes such a decision, and acts on it, risks being charged with murder if the patient dies.” *Id.*

¹⁸⁴ 355 A.2d 647.

¹⁸⁵ *Id.* at 661.

Punishment Clause¹⁸⁶ do not constitutionally protect one's right to die. The court did, however, reverse the lower court's holding and declared that one does have a right to die based on his constitutional right of privacy.¹⁸⁷ The court based its holding on the lack of any compelling state interest.¹⁸⁸ On the issue of naming Joseph Quinlan as guardian of Karen's person, the New Jersey Supreme Court also reversed. The court held that under these circumstances, the only way to protect Karen's right of privacy would be to allow that right to "be asserted in her behalf . . . by her guardian."¹⁸⁹

The court emphasized the impact of its holding on the medical profession. The New Jersey Supreme Court attacked with vigor the trial court's reluctance to address the dilemma involving the doctor's responsibility and the relationship of the court's duty by stating:

Such notions as to the distribution of responsibility, heretofore generally entertained, should however neither impede this Court in deciding matters clearly justiciable nor preclude a re-examination by the Court as to underlying human values and rights. Determinations as to these must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the Court has a nondelegable judicial responsibility.

Put in another way, the law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of. Where a Karen Quinlan, or a parent, or a doctor, or a hospital, or a State seeks the process and response of a court, it must answer with its most informed conception of justice in the previously unexplored circumstances presented to it. That is its obligation and we are here fulfilling it, for the actors and those having an interest in the matter should not go without remedy.¹⁹⁰

The court noted that "[u]nder the law as it then stood, Judge Muir was correct in declining to authorize withdrawal of

¹⁸⁶ *Id.* at 662.

¹⁸⁷ *Id.* at 662-63.

¹⁸⁸ *Id.* at 663.

¹⁸⁹ *Id.* at 664.

¹⁹⁰ *Id.* at 665-66.

the respirator.”¹⁹¹ The court, however, stated that the “medical judgment” standard adopted by the trial court did little to relieve the physicians from the pressure of civil and criminal liability. As discussed in the appellate court’s decision:

[T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.¹⁹²

Thus, the court established a new standard which provided:

Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital “Ethics Committee” or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.¹⁹³

The court additionally stated that the remedy provided by this decision would not constitute homicide.¹⁹⁴ The opinion emphasized that judicial approval to confirm such medical decisions is unnecessary and “inappropriate, not only because [it] would be a gratuitous encroachment upon the medical profession’s field of competence, but because it would be impossibly cumbersome.”¹⁹⁵

In summary, the New Jersey Supreme Court’s decision is important on four points: *First*, it implements a standard

¹⁹¹ *Id.* at 666.

¹⁹² *Id.* at 668.

¹⁹³ *Id.* at 671-72.

¹⁹⁴ *Id.* at 669.

¹⁹⁵ *Id.*

which physicians can follow without the threat of civil or criminal liability; *second*, it states expressly that judicial confirmation of such decisions would generally be inappropriate; *third*, it recognizes the right to die as being constitutionally protected by the right of privacy; and *fourth*, it devises a standard by which the guardian and family can exercise the incompetent's right to die. Although the importance of the *Quinlan* case cannot be denied, it should be noted that none of the parties intend to seek review in the United States Supreme Court.¹⁹⁶

1. *Criminal Liability of the Physicians*

Unquestionably the state does have an interest in preserving life, based upon an interest in the preservation of society, the sanctity of life, the preservation of public morals, the protection of the individual from himself, and the protection of third parties.¹⁹⁷ Without mentioning the public interest in preserving life, the *Quinlan* decision adequately dispensed with the problem of criminal liability with alternative arguments: the ensuing death would not be homicide but rather expiration from existing natural causes; and even if it were to be regarded as homicide, it would not be unlawful.¹⁹⁸

The court did not discuss its statement that the death would not be homicide but rather expiration from existing natural causes. On its face this statement appears valid, but in exploring possible variations of the *Quinlan* situation, its flaws become evident. Suppose the facts in *Quinlan* were that Karen could return to her previous full physical capacity after a pe-

¹⁹⁶ Following the New Jersey Supreme Court's decision to allow the Quinlans to exercise Karen's constitutional right to die, the Quinlans asked the treating physicians, Drs. Morse and Javed, to turn off the MA-1 respirator. Even with the New Jersey Supreme Court's decision, the doctors and St. Clare's hospital refused to discontinue the use of the respirator. The Quinlans spent 3 months searching for a medical institution which would accept Karen as a patient and would comply with the Quinlan's request to discontinue the respirator. On June 9, 1976, the Morris View Nursing Home, a publicly-operated nursing facility for indigents, admitted Karen as a patient. On June 10, 1976, counsel for Morris View announced that the ethics committee had approved the Quinlans' request to permit Karen to die a natural death without the use of a respirator. At the date of this writing, some 28 months after Karen was first placed on the respirator and some 13 months since the respirator was disconnected, Karen is still alive. COLEN, *supra* note 2.

¹⁹⁷ Cantor, *supra* note 14, at 242-54.

¹⁹⁸ 355 A.2d at 669-70.

riod of time and could lead a normal life without depending on machines. If the machines had been turned off under these circumstances, she would die of natural causes. This would appear to be murder although within the area which the court classified as not being murder. The same problem would occur if a patient with kidney damage was not allowed periodic use of a dialysis machine. Without the machine that person would die of natural causes, but no one would question that this act would constitute murder. Considering these possibilities, it appears that the first alternative of the court is weak.

The second alternative—even if the act were regarded as homicide, it would not be unlawful—is more persuasive. The court first used a definitional basis. The termination of treatment pursuant to the right to privacy is *ipso facto* lawful. Thus the act would not come within the scope of homicide statutes which proscribe only the unlawful killing of another.

Next the court contended that “the exercise of a constitutional right . . . is protected from criminal prosecution.”¹⁹⁹ Basing that theory on the United States Supreme Court case *Stanley v. Georgia*,²⁰⁰ the court stated:

We do not question the State's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy. The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime. And, under the circumstances of this case, these same principles would apply to and negate a valid prosecution for attempted suicide were there still such a crime in this State.²⁰¹

Retracing the reasoning of the court in this area, initially two unlawful acts had to be explained away: murder and suicide.²⁰² Both areas can be dispensed with by the reasoning of the court. Basically the court stated that since a constitutional

¹⁹⁹ *Id.* at 670.

²⁰⁰ 394 U.S. 557 (1969).

²⁰¹ 355 A.2d at 670 (footnotes omitted).

²⁰² As the court explained, suicide was an offense at common law, although it is not a “crime” under New Jersey law at this time. *Id.* at n.9.

right is being protected, the act is not unlawful and therefore does not constitute murder. Actually, the court plays a word game in an attempt to circumvent the state penal code, which makes no mention of the fact that a person may lawfully commit homicide.²⁰³ The second part of the analysis, based on *Stanley v. Georgia*, is better reasoned. That is, even though the conduct is unlawful, it is protected from criminal prosecution.

One has to admire the court for facing this issue so directly. It could have defined the conduct of the physicians as an omission, and since no duty would exist once the guardian demanded that the machines be turned off, the physicians would be free from criminal liability. However, the court refused to use this line of reasoning and faced the issue.²⁰⁴

2. *Guardianship and the Equity Power of the Court*

As mentioned earlier, Joseph Quinlan was required to bring legal action to be appointed legal guardian of his daughter. In Mr. Quinlan's petition for guardianship, he additionally requested the Chancery Court to exercise its equity power and grant him the express authority, as guardian, to discontinue the use of "extraordinary" medical measures.²⁰⁵ The petition requested that the court enjoin the physicians and hospital from interfering with the decree of the court as well as enjoining the state from bringing criminal charges.²⁰⁶ Thus,

Joseph Quinlan has not only asked the court for a determination as to general fitness; he is also praying the court, *parens patriae* and therefore supreme guardian, to determine that a proposed action is in the best interests of the incompetent, Karen Ann Quinlan, and to authorize the taking of that proposed action.²⁰⁷

Counsel for Joseph Quinlan argued that the principles enumerated in *Strunk* and *Hart* would apply in the right to die context. The plaintiff argued that under the substituted judgment doctrine as applied by *Strunk* and *Hart*, the court could

²⁰³ N.J. STAT. ANN. § 2A:113-2 (1965).

²⁰⁴ For a discussion of the criminality of euthanasia, see *Silving*, *supra* note 6.

²⁰⁵ QUINLAN I, *supra* note 126, Plaintiff's Complaint at 3.

²⁰⁶ *Id.* at 14.

²⁰⁷ QUINLAN I, *supra* note 126, Trial Brief for Plaintiff at 40.

exercise its equitable powers to protect Karen's best interests.²⁰⁸ The petition prayed that Karen's best interest would be served by terminating extraordinary medical means.²⁰⁹ Judge Muir responded to the plaintiff's arguments by stating:

It is also noted the concept of the Court's power over a person suffering under a disability is to *protect* and aid the best interests. As pointed out, the *Hart* and *Strunk* cases deal with protection as it relates to the future life of the infants or incompetent. Here the authorization sought, if granted, would result in Karen's death. The natural processes of her body are not shown to be sufficiently strong to sustain her by themselves. The authorization, therefore, would be to permit Karen Quinlan to die. This is not protection. It is not something in her best interests, in a temporal sense, and it is in a temporal sense that I must operate whether I believe in life after death or not. The single most important temporal quality Karen Ann Quinlan has is life. This Court will not authorize that life to be taken from her.²¹⁰

Thus, the trial court held that since there was no constitutional right to die, the court through its equitable powers could not create such a right. From the language of the opinion, however, it is evident that Judge Muir would not have allowed the substituted judgment doctrine to apply even if he had found a constitutional right to die.²¹¹

On appeal, the New Jersey Supreme Court took a different approach to the "right to die" issue. The court, in reversing the trial court, held that an individual does have a constitutional right to die under some circumstances. The court further stated that "[t]he 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 qualifications herein-after stated, as to whether she would exercise it in these circumstances."²¹² The New Jersey Supreme Court expressly stated that this decision does not imply that a proceeding for judicial relief is necessarily required for the implementation of

²⁰⁸ *Id.* at 41.

²⁰⁹ *Id.*

²¹⁰ 348 A.2d at 819-20.

²¹¹ *Id.* at 820.

²¹² 355 A.2d at 664.

comparable decisions in the field of medical practice.²¹³ Thus, from the New Jersey Supreme Court's opinion, it appears that the court is rejecting the application of the substituted judgment doctrine. The court, while stating that the guardian could assert the incompetent's "right to die," however, did restrict the guardian's power to assert the right. The opinion limited the guardian's power to assert the right to die on behalf of the ward to "these circumstances"²¹⁴ or "comparable decisions."²¹⁵ The court stated that the "guardian and family" of Karen shall be allowed to consent to discontinuance of the life-support apparatus "should the attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state" and the hospital "Ethics Committee" agrees.²¹⁶ Thus, the decision grants to the guardian the authority to exercise an incompetent's "right to die" once an irreversible condition has been verified and confirmed and the guardian's power need not be judicially affirmed by the court. Accordingly, Joseph Quinlan was appointed guardian of Karen's person with the powers prayed for but subject to the restrictions set out by the court.

III. THE FOUNDATION OF QUINLAN—THE CONSTITUTIONAL RIGHT OF PRIVACY

A. *Development of the Right of Privacy*

One of the fundamental tenets of American jurisprudence is that if an act of a private citizen can in no way injure society or any third person, it is a right. It is against this background that the right to privacy should be examined. Although this phrase is not specifically mentioned in the Constitution, it is implicit in many of the provisions and the philosophical background out of which the Constitution was formulated. Justice Brandeis articulated the theory of private rights in his dissent in *Olmstead v. United States*.²¹⁷

²¹³ *Id.* at 671.

²¹⁴ *Id.* at 664.

²¹⁵ *Id.* at 671.

²¹⁶ See generally Steele & Hill, *A Plea for a Legal Right to Die*, 29 OKLA. L. REV. 328 (1976).

²¹⁷ 277 U.S. 438 (1928).

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings, and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.²¹⁸

“The right to be let alone” is the underlying theme of the Bill of Rights. It is the “fertile soil for the cultivation of individual freedom.”²¹⁹

The definition of privacy varies with each individual, but it is clear this right includes such protection as freedom from unwanted intrusion and unwanted publicity, and a right to “intimacy.” Additionally, the right to privacy includes freedom from physical, mental, or spiritual violation and a right to the integrity of one's personality.²²⁰ Yet due to the varieties and uncertainties of an everyday definition of privacy, problems arise when attempting to define legally the boundaries of a right of privacy. The concept of a common law right of privacy was developed by Frank Warren and Louis Brandeis in 1890 when they published their famous article “The Right to Privacy.”²²¹ The authors concluded that only by embracing a broad right to an inviolate personality could the individual's privacy be protected.²²²

The issue here revolves around privacy as a constitutional

²¹⁸ *Id.* at 478.

²¹⁹ Griswold, *The Right to Be Let Alone*, 55 N.Y.U.L. REV. 216, 217 (1960). See also Dykstra, *The Right Most Valued by Civilized Man*, 6 UTAH L. REV. 305 (1959), where Dean Daniel Dykstra discusses this right comprehensively.

²²⁰ Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410 (1974).

²²¹ Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). The authors were concerned with the problem of the press “overstepping in every direction the obvious bounds of propriety and decency.” *Id.* at 196. They wanted to formulate a standard to protect individual privacy. They traced the early common law cases which recognized the right of every man “to keep his sentiments, if he pleases” and the right “to judge whether he will make them public or commit them only to the sight of his friends,” *Miller v. Taylor*, 98 Eng. Rep. 201, 242 (1769), cited in Warren & Brandeis, *supra* at 198 n.2.

²²² Warren & Brandeis, *supra* note 221, at 211.

right; the question is whether a particular private interest is so important as to be declared fundamental and therefore granted the protection of a strict scrutiny approach.²²³ Even if privacy is narrowly defined, the Constitution specifically protects some elements. The fourth amendment provides that the "right of the People to be secure in their person, houses, papers, and effects against unreasonable search and seizure shall not be violated." Some might include under the right to privacy a person's right under the fifth amendment not to be compelled to be a witness against himself.²²⁴ Yet even the privacies long protected by the Constitution are not, of course, absolute. The public good permits searches and seizures with a warrant, and sometimes, "if reasonable," on probable cause without a warrant. Self-incriminating testimony can also be compelled if the witness is given immunity from prosecution.²²⁵ The problem facing the courts now is the proper identification of the boundaries and content of the right of privacy.²²⁶

The emerging concept of privacy²²⁷ undoubtedly gives constitutional dimension to the individual's asserted right to control his body. The fourth amendment has long been a basis for the "right to be let alone."²²⁸ In *Schmerber v. California*,²²⁹ the Court applied fourth amendment limitations to a bodily invasion to obtain evidence of crime. While the Court upheld the governmental intrusion, it acknowledged that "the integrity of an individual's person is a cherished value in our society . . ." and that the human dignity and privacy at stake are a "fundamental human interest."²³⁰

²²³ Comment, *Constitutional Law—The Right to Privacy—New York Statute Interfering with Constitutionally Protected Doctor-Patient Relationship Invalidated—Roe v. Inghram*, 50 N.Y.U.L. REV. 1149, 1156-57 (1975).

²²⁴ See Griswold, *supra* note 219 at 216-17.

²²⁵ *New York Times v. United States*, 403 U.S. 713, 727-48 (1971) (White, Stewart, and Marshall, J.J., concurring).

²²⁶ Paust, *Human Rights and the Ninth Amendment: A New Form of Guarantee*, 60 CORNELL L. REV. 231 (1975).

²²⁷ See generally Fried, *Privacy*, 77 YALE L.J. 475 (1968); Griswold, *supra* note 219 at 226; Gross, *The Concept of Privacy*, 42 N.Y.U.L. REV. 34 (1967).

²²⁸ See *Stanley v. Georgia*, 394 U.S. 557 (1969); *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting). "The overriding function of the Fourth Amendment is to protect personal privacy and dignity against unwarranted intrusion by the State." *Schmerber v. California*, 384 U.S. 757, 767 (1966).

²²⁹ 384 U.S. 757 (1966).

²³⁰ *Id.* at 770, 772.

In *Griswold v. Connecticut*²³¹ the Supreme Court first recognized the right to privacy as a fundamental constitutional guarantee. In that case, the Court invalidated a Connecticut statute prohibiting the use of contraceptives by married couples and the distribution of birth control information and devices to them as violating the fundamental right to privacy. The Court presented a comprehensive treatment of the constitutional right to privacy, with the majority rendering four separate opinions, upholding that right under three distinct theories.

The opinion of the Court, by Mr. Justice Douglas, was based on several amendments²³² among the first ten: "[S]pecific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. . . . Various guarantees create zones of privacy."²³³ Justice Douglas reasoned that although the constitution nowhere specifically mentions a right to privacy, the guarantees that are expressly stated embody aspects of that right.²³⁴

Justice Goldberg, concurring, concentrated on the ninth amendment as an expression by the framers of the constitution that certain personal rights should not be denied simply because they are not expressly stated in the first eight amendments. He defined these personal rights as those so rooted in the traditions and collective consciousness of our society as to be considered fundamental.²³⁵ Justice Goldberg classified the right to privacy as one of those unenumerated rights, emanating "from the totality of the constitutional scheme under which we live."²³⁶ In determining which rights are fundamental, and therefore to be afforded the Constitution's protected status, Justice Goldberg set forth the following test:

[J]udges are not left at large to decide cases in light of their personal and private notions. Rather, they must look to the

²³¹ 381 U.S. 479 (1965).

²³² *Id.* at 484.

²³³ *Id.*

²³⁴ *Id.*

²³⁵ *Id.* at 487.

²³⁶ *Id.* at 494 (quoting *Poe v. Ullman*, 367 U.S. 497, 521 (1961) (Douglas, J., dissenting)).

"traditions and [collective] conscience of our people" to determine whether a principal is "so rooted [there] . . . as to be ranked as fundamental." The inquiry is whether a right involved "is of such a character that it cannot be denied without violating those 'fundamental principals of liberty and justice which lie at the base of our civil and political institutions.'"²³⁷

Justices Harlan and White, concurring in separate opinions, upheld the challenge to the Connecticut statute on the basis of due process under the fourteenth amendment. Mr. Justice Harlan sought to reaffirm the principle that due process can serve as a vehicle for protecting rights not specifically mentioned in the Constitution.²³⁸ Justice White found constitutional protection for unenumerated rights under the concept of "liberty."²³⁹ Neither Justice Harlan nor Justice White specifically referred to a "right to privacy," but both offered a substantive due process approach for protecting rights not enumerated in the Constitution.

The Supreme Court in *Griswold* did not define the scope of the constitutional right to privacy but left its boundaries to be determined on a case-by-case basis. In analyzing whether this unenumerated right of privacy provides any constitutional support for acts which terminate life, one must examine the cases construing the right. In *Eisenstadt v. Baird*,²⁴⁰ a case involving the regulation of contraceptive dissemination, four Justices observed: "if the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."²⁴¹ The concept of personal privacy has not been limited to matters of sexual privacy. In the context of challenges to abortion laws, this right has been extended to protect

²³⁷ 381 U.S. at 493 (citations omitted).

²³⁸ *Id.* at 499. See also Kauper, *Penumbra, Peripheries, Emanations, Things Fundamental and Things Forgotten: The Griswold Case*, 64 MICH. L. REV. 235, 245-46 (1965).

²³⁹ 381 U.S. at 502. Justice White pointed out that "there is a 'realm of family life which the state cannot enter' without substantial justification." *Id.* (quoting *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944)).

²⁴⁰ 405 U.S. 438 (1972).

²⁴¹ *Id.* at 453.

the right of a pregnant woman to determine whether to continue or terminate her pregnancy before the embryo has quickened.²⁴² *Stanley v. Georgia*²⁴³ also reinforces the notion that personal privacy extends well beyond matters of procreation. Acknowledging the "fundamental . . . right to be free, except in very limited circumstances, from unwarranted governmental intrusions into one's privacy,"²⁴⁴ the Court held that a person could not be punished for private possession of obscene material.

Numerous state and federal opinions utilizing the right to privacy indicate recognition of a right to control one's own body. In *Erickson v. Dilgard*²⁴⁵ a New York court applied the right of privacy principle to a situation in which refusal of a blood transfusion placed a patient in danger of death. Upholding the right of the patient to refuse treatment, the court asserted that under our system of government, the individual must be free to make medical decisions so long as he is competent to do so.²⁴⁶ A hospital's petition for a court order requiring a 72-year-old woman to have a blood transfusion was refused in *Palm Springs General Hospital, Inc. v. Martinez*.²⁴⁷ The court stated that "a conscious patient, who is mentally competent has the right to refuse medical treatment, even when the best medical opinion deems it essential to save her life."²⁴⁸ Likewise, the District of Columbia Court of Appeals has upheld the prerogative of a competent patient to refuse a blood transfusion by rejecting the plea of a hospital official that a guardian be appointed to authorize the treatment.²⁴⁹ Although the ma-

²⁴² *Roe v. Wade*, 410 U.S. 113 (1973).

²⁴³ 394 U.S. 557 (1969).

²⁴⁴ *Id.* at 564.

²⁴⁵ 252 N.Y.S.2d 705 (1962).

²⁴⁶ *Id.* at 706.

²⁴⁷ Case No. 71-1268 (Cir. Ct. of Dade County, Fla. July 2, 1971).

²⁴⁸ *Id. Accord, In re Raesch*, No. 455-996 (Milwaukee County Ct., filed January 27, 1972), discussed in Sullivan, *The Dying Person—His Plight and His Right*, 8 NEW ENGLAND L. REV. 197, 198, 205 (1973). In honoring Mrs. Martinez's decision, the court may well have been conforming to the accepted medical practice. That is, valuable hospital and medical resources are not usually expended upon a terminal patient who no longer desires life—prolonging treatment which offers, at best, a brief reprieve from death. See Bryn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 14 (1975).

²⁴⁹ *In re Osborne*, 294 A.2d 372 (D.C. 1972).

majority concentrated on the patient's right to reject the transfusion based on his religious beliefs,²⁵⁰ a concurring judge felt that the court's decision could be justified on "the broader based freedom of choice whether founded on religious beliefs or otherwise."²⁵¹ Even though these decisions do not specifically mention the patient's right to privacy, they nevertheless express the belief that a person may decide to reject treatment without government interference.

In *In re Yetter*²⁵² a lower Pennsylvania court upheld a patient's rejection of treatment. Mrs. Yetter, a 60-year-old inmate of a state mental institution, was examined by her physician, who discovered a possible carcinoma of the breast. She refused corrective surgery and her brother petitioned for appointment as her guardian so he could consent to the surgery. The court, citing *Roe v. Wade*,²⁵³ held:

[T]he constitutional right of privacy includes the right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life and which, to a third person at least, appear to be in his best interests; in short, that the right of privacy includes a right to die with which the State should not interfere where there are no minor or unborn children and no clear and present danger to public health, welfare or morals. . . . The Court should not interfere even though her decision might be considered unwise, foolish or ridiculous.²⁵⁴

B. *Quinlan and the Evolving Right to Die*

The constitutional right of privacy has been said to support a right to choose to die.²⁵⁵ Because the right of privacy is a fundamental right, the fact that a person's death might result from his assertion of that right should not be a basis for objection. It is submitted that the right of privacy should be viewed as a fundamental aspect of personal liberty and that therefore

²⁵⁰ *Id.* at 375.

²⁵¹ *Id.* at 376.

²⁵² 62 Pa. D. & C. 2d 619 (C.P. North Hampton County Ct. 1973).

²⁵³ 410 U.S. 113 (1973).

²⁵⁴ 62 Pa. D. & C. 2d at 623-24.

²⁵⁵ Comment, *Constitutional Law—No Constitutional Basis Exists to Permit a Parent to Assert for His Adult Child a Right to Die*, 7 TEX. TECH. L. REV. 716, 721 (1976).

a strict scrutiny approach including a search for a compelling state interest should be employed whenever governmental invasions of bodily privacy occur.²⁵⁶ In the absence of a compelling state interest, the right of privacy should allow an individual the choice of action or inaction, even though that choice may result in the individual's death.

According to the New Jersey Supreme Court, the right of privacy was "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain circumstances."²⁵⁷ Although the court stressed that such a right is not absolute and must yield to a compelling state interest, the court denied the existence of such a compelling interest in the instant circumstances. In Karen's circumstances the degree of bodily invasion was so great and her prognosis so dim that her right to privacy clearly outweighed any arguable state interest.²⁵⁸ The court also pointed out that the right to privacy would be illusory in the case of an incompetent like Karen unless it could be exercised by someone on her behalf. If Karen's guardian and family, acting as they believed Karen would have acted, chose to terminate treatment, the court felt that such a decision should be uncontradicted by society.²⁵⁹

If one accepts the New Jersey Supreme Court's analysis, then in order to justify an invasion of bodily integrity the state would have to demonstrate that a compelling state interest exists and that it outweighs the countervailing interest in individual rights.²⁶⁰ The compelling state interest standard requires careful assessment of the asserted state interest, and then a balancing of the extent of possible harm to the state against the need to uphold an individual's rights of privacy and self-determination.

The question remains as to what state interests can be

²⁵⁶ *But cf.* *Wyman v. James*, 400 U.S. 309 (1971).

²⁵⁷ *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)).

²⁵⁸ 355 A.2d at 663-64.

²⁵⁹ *Id.* at 664.

²⁶⁰ *See Stanley v. Ga.*, 394 U.S. 557, 568 n.11 (1969); Note, *Legal Analysis and Population Control: The Problem of Coercion*, 84 HARV. L. REV. 1856, 1875-79 (1971).

considered compelling. As with the right of free religious exercise, the right to privacy is not absolute, but must yield to a compelling state interest. However, at least one commentator has said that "[a] person who refused medical treatment on philosophical or moral grounds should have his right as vigorously protected as a person who refuses on religious grounds."²⁶¹ In *In re President and Directors of Georgetown College, Inc.*,²⁶² a United States Court of Appeals upheld an order requiring a mother with minor children to submit to a blood transfusion, despite her religious beliefs forbidding such medical treatment. The court's reasons for sustaining the order were three-fold: *First*, the patient was incompetent when she rejected the transfusion; *second*, the state has an interest as *parens patriae* in preventing minor children from becoming wards of the state; and *finally*, the court purported to permit the transfusion to protect the hospital and medical personnel from potential civil and criminal liability. These interests were compelling enough to overcome the individual's prerogative to refuse treatment. In his dissent Chief Justice Burger, then a circuit judge, referred to notions of privacy in his discussion of the allocation of decision-making power. He noted that Justice Brandeis in speaking of the "right to be let alone . . . intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment, even at a great risk."²⁶³

In *United States v. George*,²⁶⁴ the United States District Court of Connecticut suggested another state interest sufficient to override the right to withhold consent for medical treatment. In that case the father of four minor children refused to receive a blood transfusion because it conflicted with his religious beliefs. The court held that the state has an interest in upholding respect for the doctor's conscience and professional oath and therefore must not require a physician to forego what his re-

²⁶¹ Note, *Compulsory Medical Treatment: The State's Interest Re-evaluated*, 51 MINN. L. REV. 293, 296 (1967).

²⁶² 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964). See also discussion of this case in text accompanying note 88, *supra*.

²⁶³ *Id.* at 1015-18.

²⁶⁴ 239 F. Supp. 752 (D. Conn. 1965). See also discussion of this case in text accompanying notes 89-92, *supra*.

sponsibility requires.²⁶⁵

Because of an individual's interest in bodily integrity, the states should not be allowed to justify invading the patient's right of privacy to protect their interest in the sanctity of life. In fact, human dignity has been said to be enhanced by permitting the individual to determine for himself which beliefs are worth dying for.²⁶⁶ Such cases as *In re Estate of Brooks*²⁶⁷ and *Palm Springs General Hospital, Inc. v. Martinez*²⁶⁸ indicate that the refusal of ordinary procedures by a dying patient presents no threat to the sanctity of life significant enough to warrant state intervention.

Where a patient has minor children, the interest of the state as *parens patriae* may intervene. The state's concern in this context is that the loss of a parent will cause emotional harm to a child and burden the state with the task of supporting surviving children.²⁶⁹ However, there are numerous situations where a child may be left alone by a parent with consequent emotional upheaval in the child. Service in the armed forces, divorce, or even extended travel all result in separation of parent and child but have never been the source of state intervention; in fact, to suggest intervention would undoubtedly provoke protests of interference with personal liberty.

Basing the question of judicial intervention on financial circumstances of the patient is in effect telling the patient that his convictions will not be respected because he does not have enough money. It is arguable that such *de facto* wealth discrimination violates the Equal Protection Clause.²⁷⁰ In actuality a

²⁶⁵ *Id.* at 754. The New Jersey Supreme Court in *John F. Kennedy Memorial Hosp. v. Heston*, 279 A.2d 670, 673 (N.J. 1971), also expressed a concern for respecting physicians' judgment as to their professional responsibility in rejecting a challenge to a court order requiring a blood transfusion against a patient's will.

²⁶⁶ Cantor, *supra* note 14, at 244.

²⁶⁷ 205 N.E.2d 435 (Ill. 1965).

²⁶⁸ Case No. 71-12678 (Cir. Ct. of Dade County, Fla. (July 2, 1971)). Also, the policy of the Roman Catholic Church demonstrates that refusing extraordinary treatment presents no threat to preserving the sanctity of life. See *N.Y. Times*, Nov. 25, 1957, at 1, col. 3.

²⁶⁹ See 64 MICH. L. REV. 554, 560 (1966).

²⁷⁰ See Cantor, *supra* note 14, at 254. See generally *Klein v. Nassau County Medical Center*, 347 F. Supp. 496 (E.D.N.Y. 1972); Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW AND CONTEMP. PROB. 901, 903-07 (1970). It is also arguable, of course, that the state's economic interest simply cannot outweigh the patient's interest in bodily integrity.

patient who is not allowed to refuse medical treatment may well become more of an economic burden than an asset.²⁷¹ Although the economic factors justifying the intervention of a court are not present in every case of refusal of treatment, some judicial concern with the financial plight of a patient's survivors is both understandable and proper.

The state's interest in upholding the respect of a doctor's conscience and medical oath rests on the premise that physicians will uniformly regard honoring the refusal of treatment by a dying patient as contrary to their professional principles. Because the relationship between a doctor and a patient is consensual in nature, the physician's judgment is subservient to the patient's right to self-determination. Therefore, the assertion of a constitutional interest and bodily integrity in the context of refusal of treatment outweighs the interest of the state in upholding respect for the conscience and oath of doctors.

A majority of Americans want to be able to tell their doctor to let them die if they suffer from an incurable condition.²⁷² That this right of privacy is a valuable individual right can hardly be questioned; it is a prerequisite for psychological health,²⁷³ for experiences of love and friendship,²⁷⁴ and for liberty itself.²⁷⁵ Although the United States Supreme Court has not yet determined whether any aspect of the right to die is included in the constitutionally protected right of privacy, other courts have so held. If the medical society can be assured that the choice is a rational decision made by a competent individual, the right to a natural death with dignity and without pain must be granted.

²⁷¹ The courts cannot ignore the rising cost of medical treatment. Allowing a terminally ill patient or a patient who must receive extensive treatment to die might well be the least expensive route for a family to take. A balancing test should be utilized to determine the validity of money-saving measures which incidentally infringe upon personal liberties.

²⁷² See, e.g., *National Moves Toward Right to Death*, 2 CURRENT OPINION 39 (1975). In a Gallop poll 52% responded "yes" to the question "when a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means, if the patient and family request it?"

²⁷³ A. WESTIN, *PRIVACY IN FREEDOM* 32-39 (1967).

²⁷⁴ Fried, *Privacy*, 77 YALE L.J. 475, 482 (1968).

²⁷⁵ *Id.* at 483-84.

CONCLUSION

In summarizing the procedures available to one desiring to exercise his right to die a natural death, it is apparent that neither the courts nor the legislatures have taken the initiative to resolve the vagueness and inconsistency which exist both within and among jurisdictions. A survey of the present state of the law relating to the right to die indicates three possible theories which might be accepted as a basis for refusing extraordinary life-sustaining measures. First, the right to freedom of religion protects the right to refuse medical treatment, although this right may be curtailed by the state's interest in preserving life. Second, the courts may be sympathetic to an individual's refusal of medical treatment based upon the constitutional right of privacy argument. Third, the right to die could be resolved through statutes.

The statutory approach to resolving this issue seems to be the preferable method since it provides certainty as to how one can exercise his right to die a natural death. In addition, legislation could avoid the necessity of obtaining judicial permission before exercising the right to die. While the California legislature should be commended for its progressiveness in being the first to pass such a statute, the statute falls far short of what it should encompass. Although the California legislation may have been precipitated by the *Quinlan* case, by its express terms it would not be effective in the *Quinlan* situation. First of all, the directive that the Act authorizes can only be executed after the individual has been diagnosed as having a terminal condition.²⁷⁶ Since Karen *Quinlan* was never conscious after having been diagnosed, it would have been impossible for her to sign a directive under the California Act. Secondly, the *Quinlan* decision allowed a guardian to authorize the withdrawal of life-sustaining procedures,²⁷⁷ whereas nothing in the California legislation supports that possibility. Although nothing in the statute expressly prohibits guardian authoriza-

²⁷⁶ California Assembly Bill No. 3060, *supra* note 11, § 1 (7188, 7187(e)). The authors are assuming that Karen was in a "terminal condition" as defined in § 1 (7187(f)).

²⁷⁷ For a discussion of the *Quinlan* court's decision to grant such extraordinary powers *see* text accompanying notes 205-216 *supra*.

tion, a reading of the Act as a whole indicates that a guardian could not sign the directive for another party.

Often a patient is not diagnosed as terminally ill until after entering an unconscious state, and a natural death act such as California's should provide for this situation. The California Act states that the state legislature found that "adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition."²⁷⁸ The legislature also found that "in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient."²⁷⁹ This legislation, as enacted, does not give relief to those people who are in an unconscious state when diagnosed as terminally ill. Even though a person might not be in such a conscious state as to be capable of signing a directive, he may still be in great pain. As the California statute is now written, such people are treated inequitably.

In light of the California statute, the criticism that it is impossible to execute a legally operative living will is confounding. To alleviate the deficiencies of the California statute and avoid litigation similar to the *Quinlan* case, the authors have proposed a "Right to Natural Death Act." The proposed act is modeled after the California Act with substantial changes to remedy the deficiencies mentioned above. The most significant change is addition of a procedure for execution of a valid living will when not currently in a terminal medical state.

Right to Natural Death Act

§ 1. This act shall be known as the Right to Natural Death Act.

§ 2. The Legislature finds that adult persons have the fundamental right to control decisions relating to their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in the event of a terminal condition.

²⁷⁸ California Assembly Bill No. 3060, *supra* note 11, § 1 (7186).

²⁷⁹ *Id.*

The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of this state shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

§ 3. The following definitions shall govern the construction of this Act.

(a) "Attending physician" means the physician(s) selected by, or assigned to, the patient, who has primary responsibility for the treatment and care of the patient.

(b) "Declarant" means an individual who has executed a directive pursuant to this Act.

(c) "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of Section 4.

(d) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to the declarant, would serve only to postpone artificially the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(e) "Physician" means a physician or surgeon licensed by the _____ (state medical board)

(f) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death of the declarant.²⁸⁰

§ 4. (a) Any mentally competent person eighteen years of age or older may execute a directive. This Act establishes a rebuttable presumption that the declarant was mentally competent to execute the directive on the date of execution.

(b) The directive shall be signed by the declarant in the presence of two witnesses who:

1. Are not related to the declarant by blood or marriage;
2. Would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of laws then existing;
3. Do not have a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive; and
4. Are not attending physicians at the time of the execution of the directive.

It is not necessary that the witnesses know the content of the directive, but they must witness the signing of the directive.

(c) The directive shall be in the following form:

Directive to Physicians

Directive made this _____ day of _____ (month, year).

I, _____, being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two phy-

²⁸⁰ The authors realize that this definition is broad. However, it is necessarily broad to cover a wide variety of situations. The definition we use is identical to that used in the California Natural Death Act.

sicians, other than my attending physician(s), and where the application of life-sustaining procedures would serve only to postpone artificially the moment of my death and where my physician determines that my death is imminent as a result of aforesaid incurable injury, disease, or illness whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County and State of Residence _____

I believe the declarant to be of sound mind.

Witness _____

Witness _____

§ 5. (a) A directive may be revoked at any time by the declarant, without regard to his mental competency, by any of the following methods:

1. By being canceled, defaced, obliterated, burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction.²⁸¹

2. By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant.

²⁸¹ This subsection ties in with section 6. In effect, if the directive has been destroyed it is revoked regardless of the intent of the declarant. The authors realize that a situation might arise in which the directive was destroyed without the declarant's intent to revoke it. On the other hand, a situation might also arise in which the intent to revoke was present but all evidence indicates the intent was not present. Weighing these two possibilities, the authors determined that for the protection of the physician and the declarant, the directive must be in existence and in the possession of the physician before it can be given effect.

3. By a verbal expression by the declarant of his intent to revoke the directive.

(b) Upon revocation of a directive a declarant cannot revive the revoked directive by (1) re-executing the revoked directive or (2) revoking the revoking instrument. The individual may, however, execute a new directive separate and apart from the revoked instrument.

(c) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

§ 6. No physician or health facility which, acting in accordance with the requirements of this chapter, causes the withholding or withdrawing of life-sustaining procedures from a declarant, shall be subject to civil liability therefrom. No licensed health professional, acting under the direction of a physician who participates in the withholding or withdrawing of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician or licensed health professional acting under the direction of a physician who participates in the withholding or withdrawing of life-sustaining procedures in accordance with the provisions of this chapter shall be guilty of any criminal act or of unprofessional conduct.

§ 7. (a) Prior to effectuating a withholding or withdrawing of life-sustaining procedures from a declarant pursuant to a directive, the attending physician shall:

1. Have in his possession such directive, determine that the directive complies with Section 4, and if possible, determine that the directive is consistent with the present desires of the individual, and;

2. Secure a notarized statement from two physicians who are neither attending physicians nor witnesses to the directive, certifying that the declarant is in a terminal condition. The physician shall make the directive, or a photostatic copy thereof, and the notarized statements from the two physicians a part of the patient's medical record.

(b) Any physician who certifies the terminal condition of a patient pursuant to subsection (a)(2) may revoke such certification by notifying the attending physician either verbally or

in writing. In such instance, the attending physician shall cease the withdrawal and withholding of life-sustaining procedures until he has:

1. Secured from the certifying physician the reasons for the revocation of the certification;
2. Determined that the reasons for revocation given by the certifying physician have no basis; and
3. Procured a notarized statement from another physician in order to satisfy subsection (a)(2).

(c) No physician and no licensed health professional acting under the direction of a physician shall be criminally or civilly liable for failing to effectuate the directive of the declarant pursuant to this section; however, a failure by a physician to effectuate the directive of a declarant pursuant to this division shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements or fails to take the necessary steps to effect the transfer of the declarant to another physician who will effectuate the directive of the declarant.

§ 8. (a) The withholding or withdrawing of life-sustaining procedures from a declarant in accordance with the provisions of this Act shall not, for any purpose, constitute a suicide.

(b) The making of a directive pursuant to Section 4 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawing of life-sustaining procedures from an insured declarant, notwithstanding any term of the policy to the contrary.

(c) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or non-profit hospital service plan shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

§ 9. Nothing in this Act shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawing of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative.

§ 10. Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarant's consent shall be guilty of a misdemeanor. Any person who, except where justified or excused by law, falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 5 with the intent to cause a withholding or withdrawing of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn and death thereby to be hastened, shall be subject to prosecution for unlawful homicide as provided in _____. (state penal code).

§ 11. Nothing in this Act shall be construed to condone, authorize, or permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this Act.

§ 12. If any provision of this Act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

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