

Tulsa Law Review

Volume 12 | Issue 1

1976

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Recommended Citation

William F. Smith, *In Re Quinlan: Defining the Basis for Terminating Life Support under the Right of Privacy*, 12 Tulsa L. J. 150 (2013).

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IN RE QUINLAN: DEFINING THE BASIS FOR TERMINATING LIFE SUPPORT UNDER THE RIGHT OF PRIVACY

*We think that the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest.*¹

With these words, the New Jersey Supreme Court, in *In re Quinlan*,² unanimously concluded that the machines and medical treatment sustaining Karen Ann Quinlan's life could be withdrawn without incurring civil or criminal liability. The decision is a judicial recognition of passive, involuntary euthanasia³ for a patient whose men-

1. *In re Quinlan*, 70 N.J. 10, —, 355 A.2d 647, 664 (1976).

2. *Id.*

3. The term euthanasia originally carried the connotation of "an easy and happy death, an ideal and coveted end to a full and pleasant life." J. WILSON, *DEATH BY DECISION* 18 (1975). With the passage of time, euthanasia has come to mean an act, done with the intent to end the life of one who is terminally ill or otherwise severely restricted to a limited existence, in order to end pain and suffering or for other merciful motives. See BLACK'S LAW DICTIONARY 654 (rev. 4th ed. 1968). The ambiguity caused by this evolution has created the need to categorize and distinguish the various types of euthanasia. Thus, for purposes of clarity, distinctions between passive and active euthanasia, and between voluntary and involuntary euthanasia will be made.

Passive euthanasia involves acts of omission, such as the discontinuance of medical care in terminal cases, in order to end the useless prolongation of life. *Active euthanasia*, on the other hand, involves the commission of an act with the intent to kill the patient in order to end great suffering or to terminate a meaningless existence. O. RUSSELL, *FREEDOM TO DIE* 19-23 (1975) [hereinafter cited as RUSSELL]. Using a similar framework to define species of the problem, Professor Fletcher has suggested a further clarification of the distinction between active and passive euthanasia:

[W]hether on all the facts we should be inclined to speak of the activity as one that causes harm or one merely that permits harm to occur. The usage of the verbs "causing" and "permitting" corresponds to the distinction between acts and omissions.

Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999, 1007 (1967). Placed within this framework, *Quinlan* endorsed only passive euthanasia since the patient was permitted to die rather than directly killed. See 70 N.J. at —, 355 A.2d at 669-70. However, the court made it clear that the *Quinlan* rationale should not be considered as limited to the passive category. See note 29 *infra*.

Euthanasia can further be divided into *voluntary* and *involuntary* categories, based on whether the euthanasia decision is made by the person who dies or by others. So considered, *Quinlan* recognized involuntary euthanasia. See notes 49 and 55-61 *infra* and accompanying text.

tal and physical health has irrevocably declined to a level of vegetative existence.

Because of the lax enforcement of the criminal law⁴ and the frequent occurrence of euthanasia, without independent control and re-

4. An act performed with the intent to terminate the life of another, even though accompanied by the desire to relieve the extreme suffering of the victim or similar merciful motives, is murder. See *State v. Ehlers*, 98 N.J.L. 236, 119 A.2d 15 (1922); *People v. Roberts*, 211 Mich. 187, 178 N.W. 690 (1920); *People v. Conley*, 64 Cal. 2d 310, —, 49 Cal. Rptr. 815, 822, 411 P.2d 911, 918 (1966) (even though one “bears no ill will toward his victim and believes his act is morally justified . . . he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief.”) (dictum); R. PERKINS, *CRIMINAL LAW* 35 (2d ed. 1969).

The fact that the victim may have requested death is also theoretically irrelevant. *Turner v. State*, 119 Tenn. 663, —, 108 S.W. 1139, 1141 (1908) (“He who kills another upon his desire or command is, in the judgment of the law, as much a murderer as if he had done it of his own hand”) (citation omitted). See *People v. Roberts*, 211 Mich. 187, 178 N.W. 690 (1920).

Similarly, the low quality of life which a terminally ill patient may be permanently subjected to is not a mitigating circumstance.

The lives of all are equally under the protection of the law, and under that protection to their last moment. The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Blackburn v. State, 23 Ohio St. 146, 163 (1872).

However, when these onerous rules of law are applied to the sympathetic facts involved in cases of euthanasia, compassion generally triumphs and the rules are twisted to reach the “right” result.

[A]lthough conceptually the law does not treat mercy killing differently from other cases involving the taking of human life, in practice an exception does exist. Prosecutors, judges and juries do approach a mercy killing case differently. Public opinion does not reflect the same revulsion against an act of mercy killing that it does toward other instances of murder. . . . Although there may be opposition to mercy killing in principle, there is sympathy for the mercy killer.

Kunter, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539, 542 (1969) [hereinafter cited as Kunter]. For instance, it took a jury only forty minutes to find Robert Waskin not guilty, by reason of insanity, of the murder of his terminally ill mother. She had been shot in order to end the great pain that she was suffering. Sanders, *Euthanasia: None Dare Call It Murder*, 60 J. CRIM. L.C. & P.S. 351 (1969). See, e.g., *People v. Kirby*, 2 Parker Crim. R. 28 (N.Y. 1823) (defendant's sentence for the murder of his children in order to allow them to enjoy the spiritual world of God without further subjection to the miseries of human existence commuted by the governor); *Repouille v. United States*, 165 F.2d 152 (2d Cir. 1947) (jury's plea for “utmost clemency” for the defendant who had murdered his grossly handicapped son was granted by the trial judge by placing the father on probation); *Commonwealth v. Noxon*, 319 Mass. 495, 66 N.E.2d 814 (1946), discussed in Sanders, *supra* at 356 (sentence of death for the electrocution of defendant's mongoloid baby commuted to life, then reduced to six years with parole granted after the defendant served about four years in prison); Note, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALB. L. REV. 826, 832 (1975) (defendant doctor acquitted of a murder allegedly accomplished by the injection of poison into a pain-riddled cancer patient) (defendant found not guilty, by reason of insanity, of the murder of his brother who was paralyzed as the result of a motorcycle accident). See generally G. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1957) [hereinafter cited as WILLIAMS]; RUSSELL, *supra* note 3.

view,⁵ there exists a need for reform in the law concerning the treatment and care of the dying.⁶ Whether the New Jersey court has established a sound foundation for narrowing the gap between what has been referred to as the "Law On The Books" and the "Law In Action"⁷ is the subject of this note.

THE QUINLAN DECISION

For reasons that remain unclear, twenty-two year old Karen Ann Quinlan stopped breathing for at least two fifteen-minute periods.⁸ Arriving at a New Jersey hospital in an unconscious state, Ms. Quinlan was placed on a respirator in an effort to maintain her vital systems.⁹

5. Note, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALB. L. REV. at 827-28. See RUSSELL, *supra* note 3, at 155; note 4 *supra*. In RUSSELL, *supra* note 3, at 237-38, two physicians reported they knew that forty-three infants had been allowed to die in their hospital during a year and a half period. The decisions to allow the recently born infants to die were made with the consent of their parents. The infants were, the doctors concluded, deformed to such an extent that they lacked any possibility of enjoying "meaningful humanhood." In the *Quinlan* trial, doctors also testified about similar instances in which patients were allowed to die. 70 N.J. at —, 355 A.2d at 657. On this aspect the court observed:

We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying . . . and that they have sometimes refused to treat the hopeless and dying as if they were curable. In this sense . . . many of them have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such "therapy" offers neither human nor humane benefit.

Id. at —, 355 A.2d at 667.

6. Despite the contradictory situation presented by the laws, on the one hand, and the beliefs and practices of society regarding euthanasia, on the other, at least one writer is satisfied with the present state of affairs. As he has observed:

The Law On The Books condemns all mercy-killings. That this has a substantial deterrent effect, even its harshest critics admit. Of course, it does not stamp out all mercy-killings, just as murder and rape provisions do not stamp out all murder and rape, but presumably it does impose a substantially greater responsibility on physicians and relatives in a euthanasia situation and turns them away from significantly more doubtful cases than would otherwise be the practice under any proposed euthanasia legislation to date. When a mercy-killing occurs, however, The Law In Action is as malleable as The Law On The Books is uncompromising. The high incidence of failures to indict, acquittals, suspended sentences and reprieves lends considerable support to the view that—

If the circumstances are so compelling that the defendant ought to violate the law, then they are compelling enough for the jury to violate their oaths. The law does well to declare these homicides unlawful. It does equally well to put no more than the sanction of an oath in the way of acquittal.

Kamisar, *Some Non-Religious Views Against Proposed Mercy-Killing Legislation*, 42 MINN. L. REV. 969, 971 (1958), reprinted in *EUTHANASIA AND THE RIGHT TO DIE* 85 (E. Downing ed. 1969) (footnotes omitted) (quoting C. CURTIS, *It's YOUR LAW* 95 (1954)) [hereinafter cited as Kamisar].

7. *Id.*

8. 70 N.J. at —, 355 A.2d at 653-54.

9. The medical experts agreed that the respirator was necessary for the patient's survival, even though they were unsure how long she might live without the machine's

The lack of oxygen resulting from the interruptions of her breathing apparently caused severe brain damage¹⁰ which reduced her existence to a "vegetative state."¹¹

Aware that the chances of restoring Ms. Quinlan to a conscious and meaningful existence were virtually non-existent,¹² Mr. Quinlan sought to have his daughter's life-support system removed, thereby allowing her to die.¹³ When Ms. Quinlan's physician refused the request to terminate on the grounds that the proposed action would be contrary to medical practice and ethics,¹⁴ Mr. Quinlan requested judicial relief. He petitioned to be appointed guardian of his daughter's person with a special power to discontinue life-support measures.¹⁵ The lower court, while sympathizing with the plight of the patient and her family, denied relief, reasoning that the decision to remove the life-support system was a medical, not legal, matter.¹⁶

On appeal the New Jersey Supreme Court disagreed, placing itself in a position to directly face the euthanasia issue:

Such notions as to the distribution of responsibility, heretofore generally entertained, should 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

assistance. They also agreed that removal of the respirator would, in any event, increase the risk of brain damage. *Id.* at —, 355 A.2d at 655.

10. *Id.* at —, 355 A.2d at 654.

11. *Id.* "Dr. Fred Plum, one of [the] expert witnesses, [said this term described] . . . a 'subject who remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function.'" *Id.*

12. *Id.* at —, 355 A.2d at 655.

13. *Id.* at —, 355 A.2d at 656-57.

14. *Id.* Frequently such refusals are based on the Hippocratic Oath. RUSSELL, *supra* note 3, at 220-22; Gillon, *Suicide and Voluntary Euthanasia: Historical Perspective*, in *EUTHANASIA AND THE RIGHT TO DIE* 189-90 (E. Downing ed. 1969).

15. *Id.* at —, 355 A.2d at 651. The parties agreed that Ms. Quinlan was incompetent and that the appointment of a guardian was necessary. 70 N.J. at —, 355 A.2d at 653. The superior court accepted Mr. Quinlan as guardian of his daughter's property, but felt it was more appropriate to name another as guardian of her person. 137 N.J. Super. at —, 348 A.2d at 824. The supreme court reversed the lower court on this point and allowed the father to serve as both guardian of the person and property. 70 N.J. at —, 355 A.2d at 670-71.

16. 137 N.J. Super. at —, 348 A.2d at 819. In the alternative, the court stated that if the decision were a legal one, relief would still be denied. It reasoned:

It is also noted the concept of the court's power over a person suffering under a disability is to *protect* and aid . . . [his] best interests. . . . Here the authorization sought, if granted, would result in Karen's death. . . . 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.

Id. at —, 348 A.2d at 819-20 (emphasis in original).

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.¹⁷

Granting declaratory relief, the court held, on the authority of *Roe v. Wade*,¹⁸ that the constitutional right of privacy protected a decision to terminate medical care in certain instances.¹⁹

In analyzing the problem the court considered whether infringement of Ms. Quinlan's fundamental right to control what happened to her body²⁰ was justified by the state's interest in the "preservation and sanctity of human life and . . . the right of the physician to administer medical treatment according to his best judgment."²¹ In light of the dismal prognosis²² and the high degree of bodily invasion involved,²³ the court found that Ms. Quinlan's right to control her own body prevailed.²⁴ Apparently the state's interest would have been sufficient to justify the denial of Mr. Quinlan's request if the patient could have been returned to sapient life.²⁵

A second problem which faced the court was the inability of the patient to exercise her right to privacy by making a decision concerning her future medical care.²⁶ The court's answer was to allow the

17. 70 N.J. at —, 355 A.2d at 665.

18. 410 U.S. 113 (1973).

19. 70 N.J. at —, 355 A.2d at 663. It should be noted that the supreme court agreed with the lower court in refusing to order the termination of the life-support system and care. *Id.* at —, 355 A.2d at 660.

20. *Id.* at —, 355 A.2d at 663-64.

21. *Id.* at —, 355 A.2d at 663.

22. *Id.* at —, 355 A.2d at 664.

23. This invasion included, "24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube." *Id.*

24. *Id.*

25. *See id.* at —, 355 A.2d at 663. However, this conclusion is not free from doubt since the court added confusion to the case by declaring that the relief granted was "not intended to imply that the principles enunciated in this case might not be applicable in divers other types of terminal medical situations . . . not necessarily involving the hopeless loss of cognitive or sapient life." *Id.* at —, 355 A.2d at 671 n.10. Yet "the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological existence to which Karen seems to be doomed." *Id.* at —, 355 A.2d at 669.

26. *Id.* There was evidence of statements allegedly made by the patient expressing a desire not to be kept alive through heroic medical measures if she ever became terminally ill. *Id.* at —, 355 A.2d at 653; 137 N.J. Super. at —, 348 A.2d at 814. The supreme court agreed, in substance, with the lower court that these statements were so remote and impersonal that they lacked sufficient weight to be used as a basis for inferring the patient's choice. 70 N.J. at —, 355 A.2d at 653, 664. *See* notes 26 *supra*, and 67-75 *infra* and accompanying text.

guardian and the family of the patient to make the decision for Ms. Quinlan.²⁷ However, the court placed a procedural limitation on this delegation of authority. The power could be exercised only if the attending physicians and the hospital's "Ethics Committee"²⁸ or similar body concluded that there was little hope of recovery.²⁹

THE RIGHT OF PRIVACY

While the privacy rationale could justify the termination of medical care in a *Quinlan* situation, it does not support the *Quinlan* court's delegation of the patient's right to decide to the guardian and family. In order to analyze the court's approach, three hypothetical situations will be presented. The time of the decision to discontinue medical treatment, or the person making the decision, will be varied in each situation in order to determine the extent to which the right of privacy justifies the discontinuance of treatment.

Situation 1

Patient *A*, a single competent adult, is informed by his physician that he has a terminal illness and is hospitalized. He is told that with the use of drugs and therapy his life can be extended one or two years. Without the suggested course of care, *A* can expect to live about three months. *A* refuses to submit to treatment, arguing that involuntary treatment would violate his right to privacy.

27. 70 N.J. at —, 355 A.2d at 664. It was not clear whether the power to decide belonged solely to the guardian or was shared by the guardian and the patient's family. At one point the court vested the power solely in the guardian. *Id.* Later the court spoke as if both the guardian and the family could exercise the decision making power. *Id.* at —, 355 A.2d at 671. One source of confusion is that the guardian appointed by the supreme court was also the father of the patient. *Id.* at —, 355 A.2d at 670-71.

28. *Id.* at —, 355 A.2d at 671. Concerning the requirement, the court observed:

The most appealing factor in the technique . . . seems to us to be the diffusion of professional responsibility for decision, comparable in a way to the value of multi-judge courts in finally resolving on appeal difficult questions of law. Moreover, such a system would be protective to the hospital as well as the doctor in screening out, so to speak, a case which might be contaminated by less than worthy motivations of family or physician. In the real world and in relationship to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent.

Id. at —, 355 A.2d at 669.

29. *Id.* at —, 355 A.2d at 671. The court stated that the resulting death would not be a homicide but rather one due to natural causes. Alternatively, if the death was to be considered a homicide, the court suggested, it would be protected by the right of privacy and therefore not a violation of the law. *Id.* at —, 355 A.2d at 669-70. The court noted "[t]here is a real and in this case determinative distinction between the unlawful taking of life of another and the ending of artificial life-support systems as a matter of self-determination." *Id.* at —, 355 A.2d at 670.

Whether the patient's decision is protected by the right of privacy from any attempt to compel him to submit to treatment depends, in part, on whether his right to refuse medical treatment "can be deemed 'fundamental' or 'implicit' in the concept of ordered liberty,"³⁰ since these are the only types of interests that come within this constitutional protection.³¹ While the Supreme Court has never held that the right to refuse medical treatment is fundamental, it has found that the protection of privacy extends to an individual's decisions in areas affecting the person's bodily integrity and personal autonomy. For example, decisions regarding the extraction of evidence from the stomach of a drug suspect,³² the use of contraceptives³³ and abortion³⁴ have been found to be within the right of privacy. Because A's decision not to submit to further medical care is no less a question of bodily integrity and control, no less a question of "intimacy and importance,"³⁵ and no less a question "fundamental or implicit in the concept of ordered liberty," it is therefore no less worthy of constitutional protection than

30. *Roe v. Wade*, 410 U.S. 113, 152 (1973).

31. *Id.* This requirement suggests that a cautious case by case approach to the right of privacy and its development is being employed by the Supreme Court. Comment, *Roe and Paris: Does Privacy Have a Principle?*, 26 STAN. L. REV. 1161 (1974) [hereinafter cited as *Does Privacy Have a Principle?*]. Thus the definitive answer on the patient's right to discontinue medical care, will have to await a Supreme Court decision. At the present time, however, the Court has refused to review a case involving this issue. Delgado, *Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474, 475 (1975) [hereinafter cited as Delgado]. The parties in *Quinlan* have agreed not to seek review of the decision by the Court. *Tulsa World*, April 7, 1976, at 8a, col. 6. *But see* *Garger v. New Jersey*, 45 U.S.L.W. 3204 (1976) (petitioning Supreme Court for review of *Quinlan*).

32. *Rochin v. California*, 342 U.S. 165 (1952). While the Court did not rest the case expressly on the right of privacy, its use of the "fundamental or implicit in the concept of ordered liberty" language, *id.* at 169, and its shock at the illegal intrusion into the privacy of the suspect, *id.* at 172, strongly suggests the applicability of that doctrine. See note 30 *supra* and accompanying text.

33. *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

34. *Roe v. Wade*, 410 U.S. 113 (1973); *Doe v. Bolton*, 410 U.S. 179 (1973). The identification of these areas does not exhaust the scope of privacy's protection. The intent is to examine those areas protected by privacy which will offer the best analogy to the situation involved in *Quinlan*. Decisions in related areas which do not speak in terms of privacy, but protect private decisions from governmental intrusion under similar rationales include: *Yoder v. Wisconsin*, 406 U.S. 205 (1972) (educating children); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage partners); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (family relationships); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (raising and educating children); *Myer v. Nebraska*, 262 U.S. 390 (1923) (raising and educating children). See 410 U.S. at 152-53; Delgado, *supra* note 31.

35. Delgado, *supra* note 31, at 477. "Indeed, the decision to die is even more intimate than the decision to abort since no potentially independent entity is destroyed." *Id.* at 478 (footnote omitted).

these previously recognized areas.³⁶

The conclusion that the right to refuse medical treatment is fundamental is further supported by the protection given bodily autonomy by lower courts through the doctrine of informed consent. This doctrine, which conditions medical treatment on a patient's understanding and agreement,³⁷ is premised on the notion that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body"³⁸ While the doctrine seems to be used primarily in negligence actions involving a doctor's duty of care,³⁹ it has also been employed to analyze situations in which a patient refuses medical treatment. Even though in the majority of such cases treatment is ordered in spite of the patient's objections,⁴⁰ treatment has been withheld upon the patient's demand in at least three cases.⁴¹ These cases, rather than suggesting that decisions to refuse medical treatment are not fundamentally protected, indicate the state interests which can justify infringing such protection. Of prime importance in each case was the high degree of probability that, with the use of the objected-to course of treatment, the patient would be restored to a meaningful and cognitive existence.⁴² Another factor was the presence

36. Delgado, *supra* note 31, at 476; Moore, *The Case for Voluntary Euthanasia*, 42 U. Mo. K.C.L. REV. 327, 330 (1974); Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1203, 1244 (1973).

37. "A two-fold duty is imposed: The physician must disclose certain information about collateral risks, and he must not proceed without consent to the risks which were, or should have been, disclosed." Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. REV. 628, 630 (1970).

38. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914); *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972). See *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, 1104 (1960).

39. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Nishi v. Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960); *Wilkinson v. Vesey*, 295 A.2d 676 (R.I. 1972); *Wilson v. Scott*, 412 S.W.2d 299 (Tex. 1967); *ZeBarth v. Swedish Hosp.*, 81 Wash. 2d 12, 499 P.2d 1 (1972); *Trogun v. Fruchtmann*, 58 Wis. 2d 596, 207 N.W.2d 297 (1973). See note 37 *supra*.

40. Application of Pres. & Dirs. of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971); *Raleigh Fitkin-Paul Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964); *Muhlenberg Hosp. v. Patterson*, 128 N.J. Super. 498, 320 A.2d 518 (1974); Application of Long Island Jewish-Hillside Med. Ctr., 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973); *Powell v. Columbian Presbyterian Med. Ctr.*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965); *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964).

41. *In re Osborne*, 294 A.2d 372 (D.C. Ct. App. 1972); *Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

42. Application of Pres. & Dirs. of Georgetown College, Inc., 331 F.2d 1000 (D.C.

of minor children who, along with the community, would be adversely affected by the unnecessary death of their parent.⁴³ Finally, the need for quick action influenced the decisions.⁴⁴ As one court observed:

There was no time for research and reflection. Death could have mooted the cause in a matter of minutes, if action were not taken to preserve the *status quo*. To refuse to act, only to find later that the law required action, was a risk I was unwilling to accept. I determined to act on the side of life.⁴⁵

Because in the first hypothetical *A*'s interest in personal autonomy is so significant, the right of privacy encompasses his decision to refuse further medical treatment. As indicated by *Roe*,⁴⁶ *Quinlan*⁴⁷ and the

Cir.), *cert. denied*, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971); *Muhlenberg Hosp. v. Patterson*, 128 N.J. Super. 498, 320 A.2d 518 (1974); *Application of Long Island Jewish-Hillside Med. Ctr.*, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973).

43. In *Raleigh Fitkin-Paul Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964), a guardian was appointed for an unborn, quick child, whose mother had given advanced warning of her refusal to consent to blood transfusions. Without the transfusions, which the doctors anticipated would be vital to a successful birth, the risks to both mother and child would have been greatly increased. 42 N.J. at —, 201 A.2d at 537-38. In *Application of Pres. & Dirs. of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964), the court noted:

The patient, 25 years old, was the mother of a seven-month-old child. The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus the people had an interest in preserving the life of this mother.

331 F.2d at 1008. *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) involved a patient who was the father of four children. 239 F. Supp. at 753. In *Powell v. Columbian Presbyterian Med. Ctr.*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965), the patient was the mother of six children. The need to seek judicial authorization resulted from post-operational complications following the caesarian delivery of her sixth child. 49 Misc. 2d at —, 267 N.Y.S.2d at 451.

44. See cases cited at notes 41 and 43-44 *supra*.

45. *Application of Pres. & Dirs. of Georgetown College, Inc.*, 331 F.2d 1000, 1009-10, *cert. denied*, 377 U.S. 978 (1964). In cases where courts refused to authorize the medical procedures necessary to save the life involved, one or more of the factors previously discussed, notes 43-45 *supra* and accompanying text, were missing. For instance, in *In re Osborne*, 294 A.2d 372 (D.C. Ct. App. 1972), the court upheld a lower court order which refused to authorize medical care. The need for swift judicial action had passed since the patient had recovered by the time the case came before the higher court. 294 A.2d at 376 n.6. Also, the court emphasized the fact that the surviving parent and other family members were financially prepared to care for the children of the patient. *Id.* at 374. In *Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965), another appellate court reversed a lower court order of medical treatment. There the patient had told her doctor for two years that her religious beliefs precluded the use of blood transfusions and had received assurances, apparently by her doctor, that none would be attempted. 32 Ill. 2d at —, 205 N.E.2d at 436-37. Also, the court noted the absence of minor children of the patient. *Id.* at —, 205 N.E.2d at 442.

46. *Roe v. Wade*, 410 U.S. at 153-54.

47. 70 N.J. at —, 355 A.2d at 663.

informed consent cases,⁴⁸ the weight of the state's interest in the preservation of human life is lessened as the quality of the patient's life diminishes.⁴⁹ Thus the fact that *A*'s life expectancy is extremely short

48. See notes 42-45 *supra*.

49. In *Quinlan*, the court considered the lack of probability of restoration of the patient to a cognitive life very important. 70 N.J. at —, 355 A.2d at 663. The court stated:

The plaintiff answers that Karen's present treatment serves only a maintenance function; that the respirator cannot cure or improve her condition but at best can only prolong her inevitable slow deterioration and death; and that the interests of the patient, as seen by her surrogate, the guardian, must be evaluated by the court as predominant, even in the face of an opinion *contra* by the present attending physicians. Plaintiff's distinction is significant.

Id. at —, 355 A.2d at 663-64. In *Roe*, the Court noted:

The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

410 U.S. at 153.

The wedge principle has been raised as an objection to the idea that the predicted quality of an individual's life is a valid consideration in euthanasia decisions. Implicit in the rationale of cases such as *Blackburn v. State*, 23 Ohio St. 146 (1872) which have held that quality of a victim's life is not a mitigating factor in murder cases, the wedge argument is "that an act which, if raised to a general line of conduct would injure humanity, is wrong even in an individual case." WILLIAMS, *supra* note 4, at 315. Under this argument, allowing mercy-killing in an appealing case (such as *A*'s) is wrong because it is the thin edge of a precedential wedge which will widen the law's exceptions to murder, permitting homicide in less justifiable circumstances. Thus, permitting the withdrawal of life-support measures in hopeless cases is seen as inevitably leading to the involuntary termination of groups such as the aged, the physically handicapped, the mentally ill and the criminally insane. See *Kamisar, supra* note 7, at 1031. The Nazi program of genocide which followed a euthanasia program for the aged has been cited as an example of the operation of the wedge. *Id.* at 1031-33.

The wedge objection to euthanasia under a privacy rationale is unpersuasive for three reasons. First, the argument's assumption that permitting less offensive practices will invariably lead to more shocking ones, because it is impossible to draw a satisfactory ethical line between the two extremes, is not borne out in the euthanasia situation. The distinction between voluntary and involuntary euthanasia very clearly separates some justified cases from the unjustified cases of euthanasia. As long as euthanasia is limited to voluntary situations and the patient's choice remains meaningful, social expediency can never justify the murder of social undesirables. *Cf. RUSSELL, supra* note 3, at 90-93. Conversely, to the extent that *Quinlan* permitted involuntary euthanasia, it is vulnerable to the wedge objection. See notes 55-61 *infra* and accompanying text.

Secondly, since euthanasia is already widely practiced, see notes 4 and 5 *supra*, it is likely that, rather than leading to more horrible practices, the recognition of voluntary euthanasia would tend to restrict the practice of unauthorized, involuntary euthanasia.

Finally, the persuasiveness of the wedge argument is weakened because it could be advanced against almost any change in the social order.

weakens the importance of the state's interest.⁵⁰ A further weakening of that interest is compelled if *A*'s illness produces great pain and suffering. When this is coupled with other adverse consequences of forcing him to endure the illness as long as medically possible,⁵¹ it is clear that the state's interest in preserving life is insufficiently compelling to justify infringing his right of privacy. Thus, the right of privacy would protect *A*'s decision to refuse medical treatment.

Situation 2

B, a single adult, is involved in a car accident in which he is rendered unconscious. He is taken to a hospital where, because of his condition, a maze of life-support machines is connected to his body in order to maintain his vital systems. Afterwards it is learned that *B* has suffered severe brain damage and is doomed to a comatose existence. *B*'s father, after being informed of his son's status, seeks the disconnection of the life-support system, claiming that his son's right of privacy allows him, in behalf of *B*, to decide whether use of the life-support system should be continued.

The initial treatment of *B* is justified by a well-established exception to the rule of informed consent.⁵² This exception is applied in situations where the patient's condition demands immediate medical attention, but the patient is unable to communicate his consent to such treatment. In this type of emergency, consent is sometimes said to be implied, allowing treatment to begin in the absence of actual consent.⁵³ After emergency treatment for *B* begins, there are no socially rational options available to the medical personnel, in light of the state's policy of

[T]his type of reasoning could be used to condemn any act whatever, because there is no human conduct from which evil cannot be imagined to follow if it is persisted in when some of the circumstances are changed. All moral questions involve the drawing of a line, but the "wedge principle" would make it impossible to draw a line, because the line would have to be pushed farther and farther back until all action became vetoed.

WILLIAMS, *supra* note 4, at 315.

50. See notes 42-49 *supra* and accompanying text.

51. See note 49 *supra*.

52. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir. 1972); *Mohr v. Williams*, 95 Minn. 261, —, 104 N.W. 12, 15 (1905); *King v. Carney*, 85 Okla. 62, 64, 204 P. 270, 272 (1922); *Rolater v. Strain*, 39 Okla. 572, 577-78, 137 P. 96, 98 (1913).

53. *Mohr v. Williams*, 95 Minn. 261, —, 104 N.W. 12, 15 (1905); *Rolater v. Strain*, 39 Okla. 572, 577-78, 137 P. 96, 98 (1913). Other cases recognize this particular exception without discussing whether the consent should be implied. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir. 1972); *King v. Carney*, 85 Okla. 62, 64, 204 P. 270, 272 (1922).

preserving life, but to administer all possible care.⁵⁴ Prior to *B*'s father's request, no privacy issue is involved since a decision to discontinue life-support has not been made by, or on behalf of, the patient. Even after *B*'s father decides to discontinue life-support, the right of privacy is not a valid justification for the termination of medical care at the request of *B*'s father.

The privacy cases decided by the Supreme Court have established the individual's qualified right of control over his body in matters of personal importance.⁵⁵ *Roe*, for example, limited the power of the state to foreclose a woman's decision to terminate her pregnancy.⁵⁶ Authorizing the termination of treatment in *B*'s case on the decision of another, as the court did in *Quinlan*, is different. Instead of promoting personal control over one's body, such authorization would allow others to intrude and make a decision for the patient.⁵⁷ This judicially authorized interference with a protected decision appears to be inconsistent with the rationale of the right of privacy. This inconsistency is suggested by the recent case of *Planned Parenthood of Central Missouri v. Danforth*.⁵⁸

In *Danforth*, the Supreme Court held invalid statutes which required the consent of husbands and parents to the decisions of their wives and children, respectively, to have nonemergency abortions during the first term of their pregnancy. The Court reasoned that "since the State cannot regulate or proscribe abortion during the first stage . . . [it] cannot delegate authority to any particular person . . . to prevent abortion during that same period."⁵⁹ Clearly, under the rationale of *Danforth*, the right of privacy should not justify the termination of *B*'s treatment by his father.⁶⁰

Similarly, to the extent that *Quinlan* was decided under such a theory, it is invalid. Cloaking a determination based on social ex-

54. See 70 N.J. at —, 355 A.2d at 657.

55. See notes 31-34 *supra* and accompanying text.

56. 410 U.S. at 162-64.

57. See 70 N.J. at —, 355 A.2d at 671.

58. 96 S. Ct. 2831 (1976).

59. *Id.* at 2841. The involvement of doctors in the decision making process was not considered an unconstitutional intrusion into the patient's privacy because their function is "to advise the patient of the state of his closest physical, mental, and social associate—his own body." Delgado, *supra* note 31, at 478 (footnotes omitted).

60. Attempts by family members to prevent the rendition of medical treatment to a patient, unable to communicate, were defeated in *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1970); *Muhlenberg Hosp. v. Patterson*, 128 N.J. Super. 498, 320 A.2d 518 (1974); and *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964).

pediency under a privacy rationale in order to de-emphasize the difficult legal and moral⁶¹ issues involved, *Quinlan* suggested that its holding reflected the desires of the patient when, in fact, it effected the wishes of others. While social expediency may have been a valid ground for the decision, the court should have dealt with the issue and its attendant problems straightforwardly. Even so, the *Quinlan* court could have reached the same result under a rationale which respected the patient's privacy. This approach is presented by the last hypothetical.

Situation 3

The facts are the same as in *situation 2*. Additionally, however, *B* has expressed a desire to several members of his family and friends, on different occasions, never to have his life prolonged in the absence of a reasonable possibility of recovery. *B*'s father seeks judicial authorization to discontinue his son's life-support system on the basis that *B* has chosen to have medical care terminated in this situation.

Many times, as in this hypothetical, the full extent of the patient's injuries may not be known when treatment is initiated. When it is realized that the patient has no reasonable hope of regaining consciousness, it is too late for him to demand the withdrawal of the care maintaining his twilight existence.⁶² The issue raised is whether a prior decision, indicating the patient's refusal to consent to treatment in a certain situation, should receive the protection of privacy by requiring the implementation of that decision upon the occurrence of the specified contingencies.

It has been observed that the right of privacy has been held to protect matters involving personal control and bodily integrity.⁶³ However, the cases providing such protection did not involve decisions intended to take effect only upon the occurrence of certain future events.⁶⁴ Yet, the fact that the effect of a decision is subject to a specific occurrence should not diminish its importance as an aspect of individual liberty. The time of a decision is of least significance; of primary importance is the control over one's body in "intimate and momentous matters."⁶⁵ If *B*'s past decision is a matter within the pro-

61. See note 49 *supra*.

62. See generally *THE MOMENT OF DEATH* (A. Winter ed. 1969).

63. See notes 30-34 *supra* and accompanying text.

64. The same is true of those cases in which medical treatment was not ordered by the respective courts. See note 41 *supra*.

65. Delgado, *supra* note 31, at 477.

tection of privacy, the only difference between this situation and the first hypothetical is *B*'s inability to reiterate his decision. In such case, all that blocks the withdrawal of the life-support system are the problems presented by the use of *B*'s prior oral statements as evidence of his decision not to submit to medical treatment in the circumstances that exist.

In *Quinlan*, Ms. Quinlan's prior oral statements made before her accident, while she was competent,⁶⁶ were brought to the attention of both courts, as evidence of the patient's choice regarding the continuation of the medical care that she was receiving.⁶⁷ The essence of these statements was Ms. Quinlan's desire to avoid the useless prolongation of her life by "extraordinary means."⁶⁸ While these prior statements were, no doubt, hearsay,⁶⁹ they could have been admitted under the state of mind exception to the rule.⁷⁰ However, both courts ignored the possibility, labeling the statements too remote and impersonal to have probative value.⁷¹

Relief would be unavailable for *B* if the approach used in *Quinlan* becomes the general course of treatment of these kinds of statements. Instead of a conclusory analysis of the statements, a better approach would be to explore the reasons behind the rejection of the evidence.

66. She had made the statements in response to the situations of relatives and friends, suffering from terminal illnesses, whose lives had been prolonged through heroic measures. *Id.* at —, 355 A.2d at 653; 137 N.J. Super. at —, 348 A.2d at 814.

67. 70 N.J. at —, 355 A.2d at 653; 137 N.J. Super. at —, 348 A.2d at 814. The New Jersey Supreme Court apparently dealt with the statements as if they were offered for the purpose of inferring a present decision. *See* 70 N.J. at —, 355 A.2d at 664. The evidentiary problem is the same whether the statements are offered as a basis to infer a present or past decision.

68. *Id.* "[O]ne would have to think that the use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient." 70 N.J. at —, 355 A.2d at 668.

69. 70 N.J. at —, 355 A.2d at 653. *See* McCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE § 246 (2d ed. E. Cleary 1972) [hereinafter cited as McCORMICK].

70. *See* McCORMICK, *supra* note 69, §§ 294-95.

[I]t was made clear that declarations of mental state are generally admissible to prove the declarant's state of mind when that state of mind is at issue. But the probative value of a state of mind obviously goes beyond the state of mind itself, as indicated by general acceptance of the proposition that evidence of design or intent is relevant and admissible to show conduct.

Id. § 295 at 697.

71. 70 N.J. at —, 355 A.2d at 653. The lower court reasoned:

The conversations with her mother and friends were theoretical ones. She was not personally involved. They were not made under the solemn and sobering fact that death is a distinct choice. . . . Karen Quinlan, while she was in complete control of her mental faculties to reason out the staggering magnitude of the decision not to be "kept alive," did not make a decision.

137 N.J. Super. at —, 348 A.2d at 819 (citation omitted).

Was one of the reasons for the court's apprehension the gap between the time the statements were made and the occurrence of the tragedy?⁷² Was the court concerned with the possibility of inaccuracies and fabrications by the witnesses in reciting the oral statements at a later time?⁷³ Could the possibility that the statements were made without serious thought or in a matter-of-fact manner have troubled the court?⁷⁴ Did the gravity of the case and its consequences make the court reluctant to proceed on the sometimes suspect nature of hearsay?⁷⁵

The opportunity to examine the statements and the circumstances in which they were made should have been taken by the court. A withdrawal of life-support care based on the decision of the unconscious patient, whether considered to be a past or present one, as inferred from carefully considered prior oral statements, would have placed the court's privacy rationale on a sounder basis than did its delegation of the patient's choice to others.⁷⁶ Comprehensive treatment of the issues involved in the use of these hearsay statements, even if leading to a rejection of the statements, would have at least emphasized the need for a legislative solution. One such solution that has been offered is the living will, a version of which has been adopted by one state legislature.⁷⁷

The living will, as its name suggests, is a variation of its testamentary namesake. Instead of concerning itself with the recordation of the testator's wishes concerning the disposition of property, it is exclusively concerned with the preservation of the "testator's" decisions concerning possible future medical care. By recognizing a living will, a state, in the same way it limits how one can deal with his property, would make requirements of form which would have to be met before a past decision concerning the termination of life-support would be given effect, but when met would require the recognition of such decisions.⁷⁸

72. See McCORMICK, *supra* note 69, § 294, at 695-96.

73. *Id.* at § 245.

74. See note 70 *supra*.

75. See McCORMICK, *supra* note 69, at § 245.

76. See notes 55-61 *supra* and accompanying text.

77. Natural Death Act, ch. 1439, 1976 Cal. Legis. Serv. 6273 (West) (to be codified as CAL. HEALTH & SAFETY CODE §§ 7185-7195).

78. The document would be notarized and attested to by at least two witnesses who would affirm that the maker was of sound mind and acted of his own free will. The individual could carry the document on his person at all times, while his wife, his personal physician, a lawyer or confidant would have the original copy.

Each individual case would be referred to a hospital committee, board or a committee of physicians. . . . The committee or board would consider

Thus, the living will is based on privacy, "the principle . . . of self-determination: [n]on-interference with the liberty of action."⁷⁹

The obvious advantage of the document is that it allows the maker an opportunity for competent and serious thought concerning his desires in a situation which may deprive him of those abilities. It also offers "formal" evidence⁸⁰ to both medical and legal authorities

the circumstances under which the document was made in determining the patient's intent and also make a determination as to whether the condition of the patient has indeed reached the point where he would no longer want any treatment.

The individual could at any time, before reaching the comatose state, revoke the document. Personal possession of the document would create a strong presumption that he regards it as still binding. Statements and actions subsequent to the writing of the document may indicate a contrary intent. If the physicians find that some doubt exists as to the patient's intent, they would give treatment pending the resolution of the matter. . . .

A *living will* could only be made by a person who is capable of giving his consent to treatment. . . . A guardian should not be permitted to make such a declaration on behalf of his ward nor a parent on behalf of his child.

Kunter, *supra* note 4, at 551-52 (emphasis in original). The California Act also provides for the execution of a written document, witnessed by two disinterested people who affirm that the maker is of sound mind. Natural Death Act, ch. 1439, § 7188, 1976 Cal. Legis. Serv. 6275-76 (West). It similarly requires a determination by at least two physicians that the patient is within the reach of the Act. *Id.* § 7187(e), at 6275. Revocation can be made at any time, regardless of the competency of the patient at that time. *Id.* § 7189, at 6276. Finally, only a competent adult can execute the document. *Id.* § 7188, at 6275-76.

It is unlikely that the refusal to give effect to a patient's prior decision unless such formal requirements were met would unreasonably infringe the patient's right of privacy. See *Planned Parenthood of Cent. Mo. v. Danforth*, 96 S. Ct. 2831, 2839-40 (1976).

79. Kunter, *The Living Will, Coping with the Historical Event of Death*, 27 BAYLOR L. REV. 39, 41 (1975).

80. One format of the living will reads:

TO MY FAMILY, PHYSICIAN, MY CLERGYMAN, MY LAWYER—
If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testment of my wishes:
If there is no reasonable expectation of my recovery from physical or mental disability, I, _____ request that I be allowed to die and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age—it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that drugs be mercifully administered to me for terminal suffering even if they hasten the moment of death. This request is made after careful consideration. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to follow its mandate. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing that responsibility and of mitigating any feelings of guilt that this statement is made.

Signed _____

Date _____

Witnessed by: _____

RUSSELL, *supra* note 3, at 296-97 (taken from Euthanasia Educational Council). The California document is not as broad as Kunter's suggested living will. While the living will can be implemented when there is a lack of a reasonable possibility of recovery, note 78 *supra*, the California "Directive to Physicians" can take effect only when "death is imminent" and the use of life-support machines and care "serve only to postpone

that the maker had contemplated the situation and its consequences and had made a definite choice concerning what should be done.⁸¹ It is therefore a device that enables the potential patient to record and exercise a decision not to accept further medical treatment when it has been determined that he has virtually no hope of recovery. As such, it avoids both the useless prolongation of a meaningless existence and the evidentiary problems that troubled the *Quinlan* court, and thus permits euthanasia soundly based on the constitutional right of privacy.⁸²

CONCLUSION

*Society now recognizes that men and women have responsibility for intelligent planning of birth. Has not the time come to recognize also their responsibility for intelligent planning of death?*⁸³

Quinlan is a faltering step toward the realization of the suggested goal. It is ostensibly a recognition that the right of privacy protects a patient's decision to have a life-support system discontinued in order that the natural process of death may accomplish its mission. By accepting that the state's interest weakens when the life it seeks to protect has been permanently reduced to a vegetative level, *Quinlan* is, more significantly, a legal realization that not only the fact of life but the quality of life is a very important aspect of human existence.

the moment of death of the patient." Natural Death Act, ch. 1439, § 7187-7188, 1976 Cal. Legis. Serv. 6274-76 (West). Thus, the effect and scope of the Act would appear to be quite restrictive. This narrowness is emphasized by the section which provides: "Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter." *Id.* § 7195, at 6278.

81. It has been observed that "[c]ompliance with the total combination of requirements for the execution of formal attested wills has a marked ritual value, since the general ceremonial precludes the possibility that the testator was acting in a casual or haphazard fashion." Gulliver & Tillson, *Classification of Gratuitous Transfers*, 51 *YALE L.J.* 1, 5 (1941) (footnote omitted). Since the consequences of the living will involve the life of the maker, public policy may require that the informal, holographic type of will should not be recognized as a valid form of the living will, thereby insuring the safeguards, which formality brings, in all cases. With these requirements, the time factor between the execution of the document and the occurrence of the operative events should not concern the court, *see* text accompanying note 72 *supra*, since the idea is to provide the maker an opportunity to decide before a tragedy occurs. *See* Kunter, *supra* note 4, at 550-51. California imposes a time gap of at least 14 days between the execution of the document and the effectuation of its directive. Natural Death Act, ch. 1439, § 7191(b), 1976 Cal. Legis. Serv. 6277 (West).

82. *See* notes 55-75 *supra* and accompanying text.

83. RUSSELL, *supra* note 3, at 219.

However, *Quinlan* stumbles in its reasoning by authorizing third parties to exercise the decision of the patient. The patient's right of privacy provides a zone of protection for the exercise of choice by the patient. The judicially sanctioned entrance of third parties into this zone is not justified by the privacy rationale. The result is indeed unfortunate, since the prior oral statements of the patient might have provided a sufficient basis for finding that a decision had been made by Ms. Quinlan. Judicial recognition of this decision would have provided a sounder foundation for terminating Ms. Quinlan's life-support system under the right of privacy.

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