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A HYPOTHETICAL: QUINLAN UNDER OHIO LAW

WITH THE DECISION by all of the respondents in *In re Quinlan*¹ not to appeal their case to the United States Supreme Court,² the people in this country will have to wait for a definitive statement of law on a person's right to die and on a guardian's standing to assert that right for his ward. Because of the dearth of precedent in this area, each state court that is faced with the prospect of reviewing a case like *Quinlan* will have to grapple with its own constitutional and statutory schemes in order to make a determination of these difficult issues. It is the purpose of this comment to explore a hypothetical situation, to take the facts of the *Quinlan* case as revealed in the New Jersey Superior Court³ and the New Jersey Supreme Court opinions and interpret them under applicable Ohio law.

The facts of the case reveal that, on the evening of April 15, 1975, Karen ceased breathing for at least two fifteen-minute periods. Although there was evidence of quinine, aspirin, barbituates and traces of valium and librium in her blood, the amounts of these drugs in her bloodstream were determined to be within the therapeutic range; therefore, the cause of Karen's unconsciousness remains unknown. The attending physicians emphasized that because of the absence of a medical history on Karen, a diagnosis of her condition was necessarily tentative. However, the doctors asserted that the cessation of breathing resulted in anoxia (lack of oxygen in the blood) and in her present condition. At Newton Hospital, Karen was placed on a respirator because she could not breathe spontaneously. She was in a coma and showed evidence of decorticate posturing. On examination by Dr. Morse, a neurologist, Karen's oculocephalic and oculovestibular reflexes were normal. She was then transferred to the Intensive Care Unit of St. Clare's Hospital where a catheter was inserted and a tracheostomy performed. While on the respirator, all tests relating to the degree of acidity and the level of oxygen and carbon dioxide in her blood were normal.⁴ In addition, her blood pressure was normal.⁵ The electroencephalogram (EEG) performed on Karen indicated brain activity but failed to disclose the cause of her unconsciousness.⁶ A brain scan, an angiogram,

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

² See Medical Tribune and Medical News, May 5, 1976, at 1, col. 2 [hereinafter cited as Medical Tribune].

³ *In re Quinlan*, 137 N.J. Super. 227, 348 A.2d 801 (1975).

⁴ *Id.* at 237, 348 A.2d at 806-07.

⁵ 70 N.J. at 25, 355 A.2d at 655.

⁶ 137 N.J. Super. at 240, 348 A.2d at 808.

and a lumbar puncture showed normal results.⁷ Karen lost a great deal of weight; her weight dropped from 115 to approximately 75 pounds.⁸ Antibiotics and tests were continually administered in order to retard infection and Karen received regular nursing care. Karen's daily charts revealed her to exhibit a pale complexion, almost continuous diaphoresis (sweating), a decerebrate response to pain, yawning, spasms, occasional body rashes, occasional triggering of and assisting the respirator, occasional rigidity of her extremities, and on May 7, 1975, nurses noted that Karen blinked twice in response to their instructions. Although various attempts were made to wean Karen from the respirator (the longest period off the machine being one-half hour), they were unsuccessful as her respiratory rate would rise while her air intake volume would recede. Dr. Javed, Karen's pulmonary internist, testified that her respiratory problem was reliant on her neurological condition which did not show any improvement.⁹ Drs. Javed and Morse together with Drs. Cook, Loesser, and Plum all concurred that Karen had irreversible brain damage; there was no cognitive or cerebral functioning and some brain stem damage relating to her respiratory functioning.¹⁰

I. DEATH: THE SEARCH FOR A DEFINITION

Firstly at issue is the question: is Karen legally dead? If she is, that conclusion would obviate any problem as to what should be done. No one would be faced with any kind of liability for their actions subsequent to this determination and there would be no question of anyone's rights being invaded.¹¹ There are several definitions of death that have been offered by various authorities and have been alternatively designated as biological death, heart death, total brain death, cerebral death, and lung death. The first of these definitions is actually a misnomer. According to the biologist, there is no such thing as death; one merely experiences different stages of existence.¹² Such a definition, while philosophically provocative, offers little help in establishing a legal definition of death.

The classical definition of death is "... [A] total stoppage of the circulation of the blood, and a cessation of the animal and vital functions conse-

⁷ 70 N.J. at 23, 355 A.2d at 654.

⁸ *Id.* at 26, 355 A.2d at 655; 137 N.J. Super. at 240, 348 A.2d at 807-08.

⁹ 137 N.J. Super. at 241, 348 A.2d at 808-09.

¹⁰ *Id.* at 245, 348 A.2d at 810-11.

¹¹ Except for her family who may retain a property right in her corpse. See *Meek v. State*, 205 Ind. 102, 185 N.E. 899 (1933).

¹² Slater, *Death: The Biological Aspect*, in *EUTHANASIA AND THE RIGHT TO DEATH* 49 (Aldine De Gruyter, 1969).
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quent thereon, such as respiration, pulsation, etc."¹³ It is a static concept and has been questioned by doctors today, especially in the light of medical advances with respect to organ transplants and a more modern perspective of death as an ongoing process.¹⁴

Today, most physicians¹⁵ as well as several state statutes¹⁶ embrace brain death as determining time of death and, as Dr. Morse expressed,¹⁷ the ordinary criteria for declaring brain death are those indicia enunciated by the Ad Hoc Committee of the Harvard Medical School in their 1968 report.¹⁸ The Harvard characteristics of irreversible coma are: 1) unresponsiveness and unresponsiveness to even the most painful stimuli, 2) no spontaneous movements or breathing, 3) no reflexes and 4) a flat EEG. All tests must be repeated at least twenty-four hours later without a change

¹³ BLACK'S LAW DICTIONARY 488 (4th ed. 1968). See *Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death Report: A Definition of "Irreversible Coma"*, in THE DILEMMAS OF EUTHANASIA 161 (J. Behnke and S. Bok eds. 1975) [hereinafter cited as *Report* and as DILEMMAS]. The *Report* cites, *Smith v. Smith*, 229 Ark. 579, 317 S.W. 2d 275 (1958); *Thomas v. Anderson*, 96 Cal. App. 2d 371, 215 P.2d 478 (1950) (simultaneous death actions where the heart death definition was applied). *Report* at 165-66. See also Meyers, *Legal Aspects of Voluntary Medical Euthanasia*, in DILEMMAS 62, citing *Regina v. Potter*, a criminal case, also applying the heart death definition, wherein it was held that the defendant could only be convicted of assault because, the court concluded, a subsequent kidney transplant was the direct cause of death. Prior to the transplant, decedent was on a respirator with his heart still beating after a severe injury to his brain.

¹⁴ Address by Dr. Marvin Platt, pathologist, The University of Akron Medical-Legal Conference, May 1, 1976 [hereinafter cited as Platt and as Conference]. See also Friloux, *Death, When Does It Occur?*, BAYLOR L. REV. 10, 18 (1975).

¹⁵ Address by Dr. W. Paul Kilway, general surgeon, Conference, *supra* note 14 [hereinafter cited as Kilway]; Platt, *supra* note 14, who stressed the interdependent functions of the heart, brain, and lungs. Several books and law review articles concur with the physicians in their preference of the brain death definition of death. See O. RUSSELL, FREEDOM TO DIE 32 (1972) [hereinafter cited as RUSSELL]; Gurney, *Is There a Right to Die?*, 3 CUMBER.-SAM. L. REV. 235, 246 (1972) [hereinafter cited as Gurney]; Comment, *Legal Aspects of Euthanasia*, 36 ALBANY L. REV. 674, 688 (1972) [hereinafter cited as 36 ALBANY L. REV.]; Comment, *The Tell-Tale Heart*, 27 BAYLOR L. REV. 157 (1975) [hereinafter cited as 27 BAYLOR L. REV.]; Comment, *The Right to Die*, 10 CALIF.-WESTERN L. REV. 613 (1974) [hereinafter cited as 10 CALIF.-WESTERN L. REV.]. But see Olinger, *Medical Death*, 27 BAYLOR L. REV. 22, 25 (1975) [hereinafter cited as Olinger]. For cases accepting the brain death definition of death, see DILEMMAS, *supra* note 13, at 171-75, citing *People v. Lyons*, 15 Crim. L. Rptr. 2240 (Cal. Super Ct. 1974); *People v. Flores*, 93 Cal. Rptr. 717, vacated 98 Cal. Rptr. 822, 491 P.2d 406 (1974).

¹⁶ ALASKA STAT. §09.65.120 (Supp. 1975); KAN. STAT. ANN. §77-202 (Supp. 1972); MD. ANN. CODE art. 43 §54(F) (Supp. 1975); N.M. STAT. ANN. §1-2-2.2 (Supp. 1975); VA. CODE ANN. §32-364.3:1 (Supp. 1976). The text of these statutes may be found in *Medical-Legal Dilemmas in the Care of the Critically Ill*, [hereinafter cited as *Medical-Legal*], a handbook prepared for the Conference, *supra* note 14.

¹⁷ 137 N.J. Super. at 243, 348 A.2d at 810.

¹⁸ See *Report supra* note 13. Cf. *Merical-Legal, supra* note 16, at 2-5, citing the Minnesota criteria (irreversible damage to the brain stem) and the Pennsylvania criteria (neocortical and brain stem death).

in results and to insure the validity of this data, hypothermia or central nervous system depressants must be excluded.¹⁹

A definition of cerebral death incorporates partial brain damage where in the other two parts of the brain may continue functioning, but that part of the brain that controls cognitive powers, the cerebrum, has irreversibly ceased.²⁰ A few states have proposed legislation adopting cerebral death but to date none has passed.²¹ There is also some acceptance of this definition in the medical profession; according to one authority, where there is no hope of conscious awareness, such a definition reveals good medical practice.²² Finally, a relatively new concept is lung death. Proposed by Dr. Thomas Oliver in Pittsburgh, death would be determined where there was no pulmonary improvement after thirty days on a respirator; after that period, following a joint decision by parents (guardian), physicians, and nursing staff to discontinue treatment, the artificial life support system would be removed.²³

In the *Quinlan* case, Karen would not be considered dead under heart death and brain death definitions;²⁴ however, she would be viewed as dead under cerebral death²⁵ and lung death²⁶ determinations. It is, therefore, pivotal to examine Ohio statutory and case law to see whether Ohio has

¹⁹ *Report, supra* note 13. See 70 N.J. at 27, 355 A.2d at 656; 137 N.J. Super. at 243, 348 A.2d at 810; RUSSELL, *supra* note 15, at 197.

²⁰ See Olinger, *supra* note 15. According to Olinger, the Baylor University Medical Center in Dallas is considering a proposal endorsing the concept of brain death. The New Jersey Supreme Court approaches a declaration of cerebral death as the definition of death. 70 N.J. at 19-20 n.2, 28, 355 A.2d at 652 n.2, 657. See also Medical Tribune, *supra* note 2, at 17, cols. 3-4.

²¹ See Comment, *Proposed State Euthanasia Statute*, 3 HOFSTRA L. REV. 115, 127 (1975) [hereinafter cited as 3 HOFSTRA L. REV.], citing Ore. S.B. 179 (1973), which proposed a definition of death which included those brain damaged individuals incapable of leading a rational life. This proposed definition was not accepted. See ORE. REV. STAT. §146.087 (1975).

²² *Survey, Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1208 (1973), [hereinafter cited as 48 NOTRE DAME L.], citing Williamson, *Prolongation of Life or Prolonging the Act of Dying?*, 202 J.A. M.A. 162 (1967).

²³ Address by Dr. Gary Benfield, Director, Regional Neonatal Intensive Care Unit, Akron Children's Hospital, Conference, *supra*, note 14 [hereinafter cited as Benfield].

²⁴ Assertion by Dr. Morse, 70 N.J. at 24, 355 A.2d at 654; 137 N.J. Super. at 243, 348 A.2d at 810; by Dr. Diamond, 137 N.J. Super. at 246, 348 A.2d at 812. See American Medical News, April 12, 1976, at 17, col. 1 [hereinafter cited as Medical News]. Although Joseph Quinlan, the plaintiff, originally stated that Karen was legally and medically dead, he later changed his position to assert that, under any definition of death recognized by New Jersey, she was not dead. 70 N.J. at 20, 355 A.2d at 652; 137 N.J. Super. at 236, 348 A.2d at 806.

²⁵ 70 N.J. at 20, 355 A.2d at 657.

²⁶ Karen had been on a respirator for more than thirty days and experts agreed that she needed this aid. 70 N.J. at 25, 355 A.2d at 655.

adopted any of the above definitions. An early Ohio case, *Evans v. Halterman*,²⁷ utilized the *Black's Law Dictionary* definition of death²⁸ and identified time of death with the cessation of heart beat.²⁹ The Ohio Simultaneous Death Act³⁰ does not address itself to defining death, but the Ohio adoption of the Uniform Anatomical Gift Act³¹ does at least make reference to this determination.³² "The attending physician or a physician selected by the donor shall determine the time of death."³³ If the attending physician is unavailable, "the time of death shall be determined by two physicians having no affiliation with the donee."³⁴ The other safeguard in the Act is that those physicians certifying death may not participate in the transplant operation.³⁵ Ohio's adoption of the Uniform Anatomical Gift Act reflects a tacit acceptance of brain death in addition to heart death since the purpose of the Act is to provide a legal procedure for organ transplants. Moreover, it reveals a reliance on the medical community for determining time of death and a majority of the medical profession today seems to give credence to brain death³⁶ and to the Harvard Ad Hoc Committee's criteria.³⁷ Using the flexible definition of the Ohio Anatomical Gift Act, however, Ohio could accept cerebral or lung death definitions if support for these definitions among the medical community increased to the point where such positions were reflective of the ordinary standards of the medical profession.³⁸

To clarify Ohio's position for determining time of death, Ohio Representatives Nader and Fauver have introduced House Bill 1112. The Bill delineates death as:

... an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, an individual shall be deemed dead if, in the announced opinion of a physician as based on ordinary standards of medical practice, he has experienced an

²⁷ 31 Ohio App. 175, 165 N.E. 869 (1928).

²⁸ See text accompanying note 13 *supra*.

²⁹ 31 Ohio App. at 179-80, 165 N.E. at 870-71.

³⁰ OHIO REV. CODE ANN. §2105.21 (Page 1968).

³¹ OHIO REV. CODE ANN. §§2108.01-.09 (Page Supp. 1975).

³² OHIO REV. CODE ANN. §2108.07(B) (Page Supp. 1975).

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ See authorities cited note 15 *supra*.

³⁷ See note 19 and accompanying text *supra*.

³⁸ If these definitions did not achieve this status, the attending physician or other physician might be liable for malpractice. See notes 40-43 and accompanying text *infra*.

irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.³⁹

As yet, this Bill has not been enacted into law. In conclusion, although scant, the weight of authority seems to indicate that under the present judicial and statutory law in Ohio, a person afflicted like Karen Quinlan would not be considered dead.

II. PHYSICIAN'S DUTY OF CARE

Having made this assertion, what is the extent of medical care that legally must be given to Karen? Generally, the test of adequate medical treatment in a malpractice action in Ohio is whether a physician acted or omitted to act consistent with the acts or omissions of physicians of ordinary skill, care, and diligence, under the same or similar circumstances.⁴⁰ Further, the test for malpractice is not necessarily the recognized standards of the medical profession in this and similar communities, but may be based on a doctor's failure to use the degree of skill and care that a reasonable doctor, in similar circumstances, would have exercised.⁴¹ An Ohio court held that customary methods of treatment will not disprove malpractice where in fact such actions are negligent.⁴²

While the tests of "ordinary skill, care, and diligence"⁴³ and of the "degree of skill and care of a reasonable doctor"⁴⁴ may be easily applied in some areas of medicine, they can only receive controversial treatment in a situation like the *Quinlan* case. First, any distinction between ordinary and extraordinary care wherein the latter classification justifies removal of life-support systems is biased by the acceptance of different definitions of death and by the recognition of different presumptions of an unconscious and non-cognitive person's desire for life. Alternatively, Karen's care has been defined as ordinary⁴⁵ and as extraordinary;⁴⁶ similarly, the New

³⁹ H.B. 1112 (1976).

⁴⁰ *Ault v. Hall*, 119 Ohio St. 422, 164 N.E. 518 (1928); *Stol v. Balazs*, 32 Ohio App. 117, 167 N.E. 522 (1929).

⁴¹ *Morgan v. Sheppard*, 91 Ohio L. Abs. 579, 188 N.E.2d 808 (Ct. App. 1963).

⁴² *Id.* at 593, 188 N.E.2d at 816-17.

⁴³ See cases cited note 40 *supra*.

⁴⁴ See text accompanying note 41 *supra*. The determination of reasonableness would probably depend on expert testimony and medical opinion. Address by Dr. Sanford Press, President, Ohio State Medical Board, Conference, *supra* note 14 [hereinafter cited as Press].

⁴⁵ 137 N.J. Super. at 248, 348 A.2d at 813. See Robertson, *Involuntary Euthanasia of Defective Newborns*, 27 STAN. L. REV. 213, 236 (1975) [hereinafter cited as Robertson]. Robertson indicated that, for a patient not in an irreversible coma, the use of a respirator is ordinary care. It would only be deemed extraordinary if life itself were not seen as a benefit. *Kidway, supra note 15*, stated that the prolonged use of a respirator is normally

Jersey Supreme Court decision has been interpreted as both rejecting existing medical practice and ethical standards⁴⁷ and as codifying these selfsame procedures.⁴⁸

Ordinary means has been defined as all "medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained or used without excessive expense, pain, or other inconvenience"⁴⁹ and extraordinary means as "all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit."⁵⁰ In some ways, this delineation parallels Robertson's suggestion that a defense of necessity might be available to a physician who is faced with criminal liability for withdrawing treatment although, he admits, such defense has never been available outside of an emergency situation.⁵¹ The defense of necessity involves questions of the greater harm; where the psychological, economic, and physical suffering of the patient, his family, and society outweigh the harm of the patient's death, the doctor is justified in turning off the respirator or other life-support equipment.⁵² Essentially, Kelly's determination of ordinary care rests on the interpretation of "benefit." Can a non-cognitive patient "benefit" from *any* type of medical treatment? Perhaps, this kind of question has triggered the view that where there is no chance of a return to conscious awareness, omission of tube feedings is good medicine.⁵³

It appears that the definition of ordinary medical care fluctuates

only considered extraordinary care where the patient is terminally ill and not critically ill like Karen.

⁴⁶ The plaintiff sought the power to discontinue all extraordinary medical procedures. 70 N.J. at 18, 355 A.2d at 651. Dr. Javed testified that while the initial use of a respirator is ordinary treatment, its prolonged use coupled with extensive nursing is extraordinary care. 137 N.J. Super. at 248, 348 A.2d at 812.

⁴⁷ 70 N.J. at 25, 355 A.2d at 655, *reviewed*, Medical Tribune, *supra*, note 2, at 3.

⁴⁸ According to Dr. Sidney Diamond's conception of medical standards, where cerebral death occurs, a physician can terminate the use of a respirator. 70 N.J. at 28, 355 A.2d at 657. See Medical News, *supra* note 24, citing Dr. John Thompson.

⁴⁹ Louisell, *Euthanasia and Biathanasia*, 22 CATH. U. L. REV. 723, 736 (1973) [hereinafter cited as Louisell], citing Kelly, *The Duty to Preserve Life*, 12 THEOLOGICAL STUDIES 550 (1951).

⁵⁰ *Id.*

⁵¹ Robertson, *supra* note 45, at 239.

⁵² *Id.*

See note 22 and accompanying text *supra*. Cf. Horan, *Euthanasia, Medical Treatment and the Mongoloid Child*, 27 BAYLOR L. REV. 76, 83 (1975) [hereinafter cited as Horan]

within a given set of facts,⁵⁴ and that where a patient is mentally normal, even "extraordinary" means are willingly employed.⁵⁵ "The 'quality' of remaining existence, rather than the complexity or difficulty of proposed treatment, becomes the principal determinant of what is extraordinary . . ."⁵⁶

Other criteria that have been suggested to determine what is ordinary medical treatment are custom and the expectations of the patient.⁵⁷ This definition is rooted in the contract terminology consistent with the notion that a doctor's liability for an omission is derived from the patient-physician's contractual relationship.⁵⁸ In Ohio, even an unconscious patient may contract with a consenting doctor⁵⁹ and once the doctor assumes this bond, he cannot evade his responsibility to his patient without giving him reasonable time to procure other adequate medical aid.⁶⁰ While the expectations of the conscious patient may be ascertained fairly readily, those of the comatose or non-cognitive patient are uncommunicable. Therefore the courts must make one of two presumptions: that such a patient either would⁶¹ or would not⁶² consent to life-preserving treatment. Either presumption again rests on one's interpretation of the value of a non-cognitive existence. An alternative suggestion is that the doctor-patient relationship includes implied consent

⁵⁴ See 70 N.J. at 48, 355 A.2d at 668; 137 N.J. Super. at 248, 348 A.2d at 812; Kilway, *supra* note 15; Russell, *supra* note 15, at 141, *citing* Dr. Perrin Long; Comment, *Antidys-thanasia Contracts*, 5 PAC. L.J. 738, 741 (1974) [hereinafter cited as 5 PAC. L.J.].

⁵⁵ See Horan, *supra* note 53, at 85.

⁵⁶ See Cantor, *Law and the Termination of an Incompetent Patient's Life-Preserving Care*, in DILEMMAS, *supra* note 13, at 78 [hereinafter cited as Cantor].

⁵⁷ See Gurney, *supra* note 15, at 247.

⁵⁸ See Robertson, *supra* note 45, at 225. A physician's initial refusal to enter this contractual relationship would absolve him of liability. See also *Limbaugh v. Watson*, 12 Ohio L. Abs. 150 (Ct. App. 1932). Once that relationship is established, he or she must exercise reasonable care. The controversy of whether turning off a respirator constitutes an act or an omission is immaterial where a physician and his patient maintain this contractual relationship. See generally Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967). Moreover, the initial decision to put a patient on a respirator is usually to "buy time". Benfield, *supra* note 23. There is no logical distinction between a decision not to use a respirator at all and a decision to turn one off. Russell, *supra* note 15, at 145, *citing* Dr. William Williamson. There is also no legal distinction within the confines of the contractual duty between doctor and patient.

⁵⁹ *Tucker v. Gillette*, 22 Ohio C.C.R. 664 (1901), *aff'd*, *Gillette v. Tucker*, 67 Ohio St. 106, 65 N.E. 865 (1902). In *McArthur v. Bowers*, 72 Ohio St. 656, 76 N.E. 1128 (1905) (per curiam), the court adopted the dissenting opinion in *Gillette*. However, the doctrine of *Gillette* was re-established in *Bower v. Santee*, 99 Ohio St. 361, 124 N.E. 238 (1919).

⁶⁰ *Bower v. Santee*, 99 Ohio St. 361, 124 N.E. 238 (1919).

⁶¹ See 137 N.J. Super. at 269, 348 A.2d at 823. See also Sharp and Croft, *Death with Dignity*, 27 BAYLOR L. REV. 86, 98 (1975) [hereinafter cited as Sharp].

⁶² The New Jersey Supreme Court asserted it had no doubt that if Karen were momentarily lucid, she would choose a natural death. 70 N.J. at 39, 355 A.2d at 663.

to an omission if that is the medical custom.⁶³ Because the standards of the medical profession are ambiguous⁶⁴ and because some members of the medical profession would prefer that customary standards were not definitively established,⁶⁵ such a touchstone as applied in a Quinlan-type situation is not very helpful.

III. PHYSICIAN'S LIABILITY UNDER PRESENT OHIO LAW

According to Dr. Sanford Press, President of the Ohio State Medical Board, the decision to withdraw or withhold treatment from a critically ill patient such as Karen could involve questions of suspension or revocation of that physician's license to practice medicine⁶⁶ and therefore would involve an interpretation of Ohio Rev. Code Section 4731.22⁶⁷ and specifically Section 4731.22(B)(6)⁶⁸ as to whether or not such action would be considered a departure from "minimal standards of care of similar practitioners under the same or similar circumstances . . ."⁶⁹ If the court determined that the physician was criminally liable for his act, his license could also be revoked.⁷⁰ Moreover, a physician's license can be revoked or suspended if he violates any provision of the A.M.A. Code of Ethics.⁷¹ As noted by Dr. Press,⁷² Sections 4, 5, and 6 of the Code, dealing respectively with professional competence, neglect of patients, and conditions tending to effect a poorer quality of medical care, are particularly applicable here.⁷³

In addition to the possibility of liability for malpractice and of license suspension and revocation, a doctor's decision to withdraw a life-support system from his patient might create a liability for child abuse,⁷⁴ for endangering children⁷⁵ or for wrongful death.⁷⁶

⁶³ See Vodiga, *Euthanasia and the Right to Die — Moral, Ethical and Legal Perspectives*, 51 CHI.-KENT L. REV. 1 (1974) [hereinafter cited as Vodiga].

⁶⁴ See 70 N.J. at 46, 355 A.2d at 667.

⁶⁵ See 137 N.J. Super. at 263, 348 A.2d at 821.

⁶⁶ Press, *supra* note 44.

⁶⁷ OHIO REV. CODE ANN. §4731.22 (Page Supp. 1975).

⁶⁸ OHIO REV. CODE ANN. §4731.22(B)(6) (Page Supp. 1975).

⁶⁹ *Id.*

⁷⁰ OHIO REV. CODE ANN. §4731.22(B)(11) (Page Supp. 1975) (conviction of felony or misdemeanor committed in the course of his practice).

⁷¹ OHIO REV. CODE ANN. §4731.22(B)(15) (Page Supp. 1975).

⁷² See Press note 44 *supra*.

⁷³ *Id.* See also Medical-Legal, *supra* note 16, at 33-34, citing the AMA Code of Ethics.

⁷⁴ OHIO REV. CODE ANN. §2151.031 (Page Supp. 1975).

⁷⁵ OHIO REV. CODE ANN. §2919.22 (Page Supp. 1975).

⁷⁶ Ohio Rev. Code Ann. §2125.01-.04 (Page 1968). However, if the parents or guardian agreed to the decision, they would be estopped from recovering.

A concomitant to the question of what is the extent of medical care that legally must be given to Karen is the question: who is to make the determination of the proper care for critically ill patients? The New Jersey Supreme Court in *Quinlan* urged the formation of Ethics Committees in hospitals;⁷⁷ adopting Dr. Teel's suggestion,⁷⁸ the Court recommended that the decision to withdraw life-support equipment be based on a group decision. Professor Mary Manuszak of the University of Akron College of Nursing stated that the team approach would result in a collection of knowledge and group support for the group's decision.⁷⁹ According to Robertson, a decision-making body might be more capable of assessing the different interests involved in each case than would a single physician.⁸⁰ However, Robertson noted that such a procedure could become too cumbersome and bureaucratized.⁸¹ He warns, "... such a committee structure risks losing society's pervasive symbolic commitment to the value of individual life, as well as embarking on the slippery path of rational-utility assessments of personal worth."⁸² In addition, some physicians, while accepting the position that consultants should be made available to them, reject the committee approach and assert that the attending physician who has made all previous medical decisions must alone direct the decision of whether to withdraw a life support system from the patient.⁸³

If a doctor withdraws the respirator from a patient like Karen, under Ohio law, is that physician liable for aiding or abetting a suicide or for committing homicide? In Ohio, suicide is not an offense;⁸⁴ moreover, in Ohio, it does not raise the presumption of insanity.⁸⁵ Because there is no

⁷⁷ 70 N.J. at 49, 355 A.2d at 668.

⁷⁸ *Id.* See Teel, *The Physician's Dilemmas A Doctor's View: What Should The Law Be*, 27 BAYLOR L. REV. 6 (1975).

⁷⁹ Address by Professor Mary Manuscak, University of Akron College of Nursing, Conference, *supra* note 14.

⁸⁰ Robertson, *supra* note 45, at 264.

⁸¹ *Id.* at 265.

⁸² *Id.*

⁸³ See Kilway, *supra* note 15.

⁸⁴ *Blackburn v. State*, 23 Ohio St. 146, 153 (1872). Although English common law considered suicide a felony, this classification is no longer valid in the majority of states and in England. See generally Mathews, *Voluntary Euthanasia*, in EUTHANASIA AND THE RIGHT TO DEATH 25 (A. Downing ed. 1969); J. WILSON, *DEATH BY DECISION* 130 (1975) [hereinafter cited as WILSON]; Kirven, *The Right to Die*, 39 KY. B. & B. 16 (1975).

⁸⁵ *Wheeler v. State*, 34 Ohio St. 394, 398-99 (1879), citing *Blackburn v. State*, Ohio St. 146 (1872), and stating that even one who was disposed to suicide and who was for six years in a melancholy disposition may be ruled competent. *Id.* at 399. See *Speece v. Industrial Commission*, 46 Ohio L. Abs. 453, 70 N.E.2d 387 (Ct. App. 1945). Despite the common law held belief that a suicidal person is incompetent to make decisions, in some circumstances suicide may be rational and even proper. Sharp, *supra* note 61 at 97; Barrington, *supra* note 10 at 100.

liability for suicide, no one in Ohio may be charged with being an accessory or principal in the second degree to suicide.⁸⁶ There is, however, in Ohio a presumption against suicide⁸⁷ and such may be the basis for regarding an act similar to a physician's removal of a respirator as a homicide.⁸⁸ While suicide and aiding a suicide may not be crimes in Ohio, an act by a physician, such as offering a lethal dose of morphine to a terminal patient may⁸⁹ or may not⁹⁰ constitute *administering* a lethal dose and consequently could be interpreted as homicide. Similarly, the act of removing a patient from a respirator might be interpreted as "administering" death. In *Blackburn v. State*,⁹¹ where the defendant furnished poison for the deceased with the intent for her to commit suicide and where the deceased accomplished this act, he had "administered the poison to her within the meaning of the statute" and was liable for her murder.⁹² The pivotal question in deciding if an act is homicide or aiding and abetting a suicide is often who is the instigator of the act.⁹³

Where death results from suicide, under Ohio law, a physician is required to notify the coroner of this fact.⁹⁴ It is the coroner, moreover, who makes a determination of the cause of death and who subsequently notifies the prosecutor if such cause is suspicious.⁹⁵ The pertinent sections of the Ohio Revised Code that decide whether a physician who removes a patient like Karen from a life-support system is criminally liable for this

ton, *Apologia for Suicide*, in EUTHANASIA AND THE RIGHT TO DEATH 152 (A. Downing ed.) [hereinafter cited as Barrington]. In New Jersey persons attempting suicide are temporarily hospitalized. 70 N.J. at 52 n.9, 355 A.2d at 670 n.9.

⁸⁶ Address by Professor Robert Hopperton, University of Dayton College of Law, Conference, *supra* note 14 [hereinafter cited as Hopperton]. See Annot., 25 A.L.R. 1007-08 (1923). Similarly, in Texas, where suicide is not a crime, it is not a crime to aid or abet suicide. See generally Annot., 13 A.L.R. 1260 (1921). However, hospitals have been held liable for failing to prevent suicides in non-terminal patients. Sharp, *supra* note 61, at 86.

⁸⁷ A strong presumption to this effect may be found in *Carson v. Metropolitan Life Ins. Co.*, 156 Ohio St. 104, 100 N.E.2d 197 (1951); a weak presumption was asserted to exist in *Hrybar v. Metropolitan Life Ins. Co.*, 140 Ohio St. 437, 442, 45 N.E.2d 114, 117 (1942). Because of man's instinct to preserve life, it is improbable that someone would intentionally commit suicide. *Shepherd v. Midland Mutual Life Ins. Co.*, 152 Ohio St. 6, 16, 87 N.E.2d 156, 162 (1949).

⁸⁸ See generally Annot., 25 A.L.R. 1007 (1923).

⁸⁹ *Blackburn v. State*, 23 Ohio St. 146 (1872). See generally Annot., 13 A.L.R. 1260 (1921).

⁹⁰ See Hopperton, *supra* note 86.

⁹¹ 23 Ohio St. 146 (1872).

⁹² *Id.* at 163.

⁹³ See Annot., 13 A.L.R. 1261-62 (1921).

⁹⁴ OHIO REV. CODE ANN. §313.12 (Page Supp. 1975).

⁹⁵ Address by Stephen Gabalač, Summit County (Ohio) Prosecutor, Conference, *supra* note 14.

act are Sections 2903.01⁹⁶ and 2903.02⁹⁷. Section 2903.01 imposes liability for aggravated murder upon anyone who "shall purposely, and with prior calculation and design, cause the death of another."⁹⁸ Section 2903.02 defines murder as follows: "(A) No person shall purposely cause the death of another. (B) Whoever violates this Section is guilty of murder, and shall be punished as provided in Section 2929.02 of the Revised Code."⁹⁹

Because the Ohio definition of murder emphasizes causation, the definition of death that Ohio ultimately adopts would determine a physician's liability. If Ohio adopts House Bill 1112,¹⁰⁰ a physician's act of removing the respirator from a patient like Karen would render that doctor liable for murder and aggravated murder.¹⁰¹ The New Jersey Supreme Court suggested that Karen's death would not be caused by the physician's act but would result from natural causes.¹⁰² It should be noted, however, that the New Jersey Supreme Court seems to have embraced the cerebral death determination of death.¹⁰³ The fact that the victim consented to homicide is immaterial to criminal liability.¹⁰⁴ Similarly, motive, or lack of malice, is not at issue in a murder charge in Ohio.¹⁰⁵ Moreover, the defense of necessity is not normally available in a non-emergency situation.¹⁰⁶ It is, therefore, likely that under Ohio law a physician's act of removing life-support equipment from a critically ill patient would result in criminal liability; however, it should also be noted that juries generally acquit physicians of these charges.¹⁰⁷

⁹⁶ OHIO REV. CODE ANN. §2903.01 (Page Supp. 1975).

⁹⁷ OHIO REV. CODE ANN. §2903.02 (Page Supp. 1975).

⁹⁸ OHIO REV. CODE ANN. §2903.01(A) (Page Supp. 1975).

⁹⁹ OHIO REV. CODE ANN. §2903.02 (Page Supp. 1975).

¹⁰⁰ See Ohio H. B. 1112 (1976).

¹⁰¹ Professor Robert Hopperton indicated that, in his opinion, present Ohio law would create liability for the physician. Hopperton, *supra* note 86. Similarly, in Texas, a physician who participated in involuntary euthanasia would be liable for murder. See Forman, *The Physician's Criminal Liability for the Practice of Euthanasia*, 27 BAYLOR L. REV. 54 (1975) [hereinafter cited as Forman].

¹⁰² 70 N.J. at 51, 355 A.2d at 670.

¹⁰³ 70 N.J. at 19-20 n.2, 28, 355 A.2d at 652 n.2, 657.

¹⁰⁴ See Forman, *supra* note 101; 48 NOTRE DAME LAW., *supra* note 22. See generally Annot., 71 A.L.R. 2d 617 (1960). However, evidence of motive may be admitted for the purpose of setting a penalty. 48 NOTRE DAME LAW., *supra* note 22.

¹⁰⁵ Hahn v. State, 38 Ohio App. 461, 176 N.E. 164 (1930). See generally People v. Robert, 211 Mich. 187, 178 N.W. 690 (1920); State v. Ehlers, 98 N.J.L. 236, 119 A. 15 (Ct. App. 1922).

¹⁰⁶ See authorities cited note 45 *supra*.

¹⁰⁷ See RUSSELL, *supra* note 15, at 260.

IV. CONSTITUTIONAL LAW QUESTIONS

What are Karen's constitutional rights in Ohio? Can she order her doctor to stop treatment? The Ohio Constitution provides for freedom from cruel and unusual punishment consistent with the Eighth Amendment of the federal constitution.¹⁰⁸ According to Justice Brennan's concurring opinion in the *Furman* case,¹⁰⁹ this constitutional guarantee is linked with concepts of human dignity. That viewpoint, in turn, has evoked the question of whether the privilege against cruel and unusual punishment embodies a correlative right to human dignity.¹¹⁰ This question, while circumventing a narrow and limited application of the Eighth Amendment, would shed little light on the question of Karen's rights since there would remain the threshold issue of whether withdrawing the life-support system under these circumstances would promote human dignity,¹¹¹ which is not so different from the question of whether keeping Karen on the respirator is cruel and unusual punishment.¹¹² Both New Jersey courts in the *Quinlan* case held that the Eighth Amendment was not material to the facts of that case¹¹³ and that the scope of this privilege, as established in *Furman*, is confined to state-imposed criminal sanctions.¹¹⁴

The Ohio Constitution also provides for free exercise of religion.¹¹⁵ Karen, a Roman Catholic, has constitutional protection for her religious beliefs; however, as both courts in the *Quinlan* case noted,¹¹⁶ the state may regulate religious practice where such conflicts with the government's overriding interest in preserving life.¹¹⁷ Moreover, it is not a mortal sin according

¹⁰⁸ U.S. CONST. amend. VIII; OHIO CONST. art. I, §9.

¹⁰⁹ *Furman v. Georgia*, 408 U.S. 238, *petition for rehearing denied*, 409 U.S. 902 (1972).

¹¹⁰ See Forkosch, *Privacy, Human Dignity, Euthanasia—Are These Independent Constitutional Rights?*, 3 U.S.F.V. L. REV. 1, 17.

¹¹¹ One of the pro-euthanasia arguments suggests that such action will promote human dignity. See Moore, *The Case for Voluntary Euthanasia*, 42 U. MO. K.C. L. REV. 327, 332 (1974) [hereinafter cited as Moore] the lower court in the *Quinlan* case concluded, "Continuation of medical treatment, in whatever form, where the goal is sustenance of life, is not something degrading, arbitrarily inflicted, unacceptable to contemporary society or unnecessary." 137 N.J. Super. at 269, 348 A.2d at 824.

¹¹² See Flew, *The Principle of Euthanasia*, in EUTHANASIA AND THE RIGHT TO DEATH 30 (A. Downing ed. 1969); Williams, *Euthanasia Legislation: A Rejoinder to the Non-Religious Objections*, in EUTHANASIA AND THE RIGHT TO DEATH 134 (A. Downing ed. 1969) [hereinafter cited as Williams].

¹¹³ 70 N.J. at 37, 355 A.2d at 662; 137 N.J. Super. at 269, 348 A.2d at 823-24.

¹¹⁴ 70 N.J. at 37, 355 A.2d at 662; 137 N.J. Super. at 268, 348 A.2d at 823-24.

¹¹⁵ OHIO CONST. art. I, §7.

¹¹⁶ 70 N.J. at 36, 355 A.2d at 661; 137 N.J. Super. at 266, 348 A.2d at 822.

¹¹⁷ 137 N.J. Super. at 267, 348 A.2d at 823. The state's interest is particularly compelling where a child or a non-consenting adult is involved. See generally Annot., 9 A.L.R. 3d 1391 (1966).

to Catholic doctrine and the Papal *allocutio* of November 24, 1957 to continue Karen's treatment.¹¹⁸ This fact contributed to the New Jersey Supreme Court's conclusion that "... ranged against the State's interest in the preservation of life, the impingement of religious belief, much less religious 'neutrality' as here, does not reflect a constitutional question, in the circumstances at least of the case presently before the Court."¹¹⁹

Ohio recognized an individual's right to privacy in *Housh v. Peth*,¹²⁰ a case in which plaintiff, a debtor, was continually harrassed by telephone calls at her home and at work from defendants who owned a collection agency. In *Housh*, the court held that such actions by defendants which caused plaintiff mental anguish constituted an invasion of her right to privacy. Further, in *LeCrone v. Ohio Bell Tel. Co.*,¹²¹ a case which involved defendant's installing an extension into plaintiff's phone line at her estranged husband's home without her knowledge, the appellate court enunciated a test for an actionable invasion of a plaintiff's right to privacy: defendants' acts must be measured against what is "offensive or objectionable to the reasonable man."¹²² Essentially, the nature of the right to privacy is "to be left alone" in matters that are not public.¹²³ Implied consent, however, may limit this right.¹²⁴ The New Jersey Supreme Court, in the *Quinlan* case, based their decision on Karen's right to privacy; the court held, "... 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."¹²⁵ While Ohio might find that Karen has a right of privacy, it may also find an implied consent to treatment which would be a defense to the invasion of this right.¹²⁶ The extent of treatment impliedly consented to by an unconscious patient who has not made known her desires by a "living will"¹²⁷

¹¹⁸ See 70 N.J. at 31, 355 A.2d at 658-59; 137 N.J. Super. at 249, 267, 348 A.2d at 813, 823.

¹¹⁹ 70 N.J. at 36, 355 A.2d at 661.

¹²⁰ 165 Ohio St. 35, 133 N.E.2d 340 (1956). The United States Supreme Court specifically recognized a constitutional right to privacy in *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹²¹ 120 Ohio App. 129, 201 N.E.2d 533 (1963).

¹²² *Id.* at 131, 201 N.E.2d at 536.

¹²³ 165 Ohio St. 35, 39, 133 N.E.2d 340, 343 (1956). The right to be left alone may be interpreted as codifying the right to commit suicide regardless of motive. See Sharp, *supra* note 61, at 98.

¹²⁴ *Martin v. F.I.Y. Theatre Co.*, 10 Ohio Op. 338 (C.P. Cuyahoga County 1938).

¹²⁵ 70 N.J. at 41, 355 A.2d at 664.

¹²⁶ See *Martin v. F.I.Y. Theatre Co.*, 10 Ohio Op. 338 (C.P. Cuyahoga County 1938).

¹²⁷ Advocates of the "living will" concept include: Downing, *Euthanasia: The Human Context*, in *EUTHANASIA AND THE RIGHT TO DEATH* 20 (A. Downing ed. 1969); M. MANNES, 14

or by other means prior to her illness, must still be ascertained. Is there a presumption that one chooses to live even with a non-functioning cerebrum?¹²⁸ Furthermore, is a patient with a non-functioning cerebrum considered alive under Ohio law?¹²⁹

In *Quinlan*, the plaintiff asserted that Karen has the right to self-determination,¹³⁰ a right that is considered part of the general right to privacy.¹³¹ The right to self-determination embodies the value of individual freedom and, within the context of this situation, asserts that a patient has the right to make his own decisions.¹³² Since, according to Ohio law, treatment without consent of the patient may constitute assault and battery,¹³³ and since a patient may, in the absence of an agreement to the contrary, discharge a physician at any time,¹³⁴ an Ohio court may infer an adult patient's right to refuse medical treatment.¹³⁵ Yet, the problem with such an inference in the instant situation is that an incompetent, critically ill patient cannot communicate how he or she would use this right to self-determination.¹³⁶

Because of the right to refuse medical care and the absence of criminal sanctions against suicide, some writers have inferred a right to die that may be asserted by competent adults.¹³⁷ According to one article,¹³⁸ the right

LAST RIGHTS 105 (1974) [hereinafter cited as MANNES]; Kutner, *The Living Will*, 27 BAYLOR L. REV. 39 (1975) [hereinafter cited as Kutner]; Moore, *supra* note 114, at 335, 337; 48 NOTRE DAME LAW., *supra* note 22, at 1244; 10 CALIF.-WESTERN L. REV. *supra* note 15; Comment, *Due Process of Euthanasia*, 44 IND. L.J. 539 (1969) [hereinafter cited as 44 IND. L. J.]; 5 PAC. L. J., *supra* note 54. Cf. Vodiga, *supra* note 63, at 12. See also OHIO H.B. 1235 (1976).

¹²⁸ See notes 61-63, 87 and accompanying text *supra*.

¹²⁹ See notes 28-39 and accompanying text *supra*.

¹³⁰ 137 N.J. Super. at 251, 348 A.2d at 814.

¹³¹ *Id.*

¹³² See Wilson, *supra* note 84, at 138.

¹³³ *Lacey v. Laird*, 166 Ohio St. 12, 139 N.E.2d 25 (1956).

¹³⁴ See cases cited note 59 *supra*.

¹³⁵ See RUSSELL, *supra* note 15, at 38-41, citing *Palm Springs Gen. Hosp. v. Martinez*, case no. 71-12678 (Cir. Ct. Fla. 1971), *Guardianship of Gertrude Raasch*, case no. 445-996 (Cir. Ct. Wis. 1972), and the *Bentley* case, Misc. No. 65-74 (Super. Ct. D.C.). See also Horan, *supra*, note 53, at 81; 10 CALIF.-WESTERN L. REV., *supra*, note 15; Comment, *The Right of a Patient to Refuse Blood Transfusions*, 3 U.S.F.V. L. REV. 91 (1974) [hereinafter cited as 3 U.S.F.V. L. REV.]; note, *Informal Consent and the Dying Patient*, 84 YALE L. J. 1632, 1648 (1974); note, *An Adult's Right to Resist Blood Transfusions*, 47 NOTRE DAME L. 571, 587 (1972). See generally Annot., 9 A.L.R. 3d 1391 (1966).

¹³⁶ See Hopperton, *supra* note 86.

¹³⁷ See Barrington, *supra* note 85, at 163; Comment, *Voluntary Euthanasia*, 39 ALBANY L. REV. 826 (1975); Comment, *The Right to Die*, 7 HOUSTON L. REV. 654, 667-68 (1970) [hereinafter cited as 7 HOUSTON L. REV.].

to death is embodied in the right to liberty and in the right to pursue happiness.¹³⁹ Legislation has been proposed to codify this alleged right¹⁴⁰ but to date none has passed. Some writers, however, deny its existence.¹⁴¹ To them, it is a confusing euphemism based on the specious argument that where there is a right to life there is a correlative right to death.¹⁴² In the *Quinlan* case, the defendants relied on the *Heston* case to assert there is no constitutional right to die¹⁴³ and the Superior Court of New Jersey refused to recognize this right.¹⁴⁴

Assuming *arguendo* that Karen had a right to privacy under these circumstances and that this right included a right to self-determination (if not also the right to die), did Karen's father have standing to assert these rights either for her or for himself as her parent? Because Karen was comatose and had a non-functioning cerebrum, she could not make the assertions that a competent adult could make in the exercise of her right to self-determination.¹⁴⁵ Prior to her illness, Karen had made some general statements to her mother and to friends that she would rather be allowed to die than be kept alive by extraordinary means.¹⁴⁶ At trial, however, there was no other evidence produced relating to Karen's position on self-determination; she had not written a document such as a "living will"¹⁴⁷ to indicate her wishes under these conditions.¹⁴⁸

The New Jersey Supreme Court granted Mr. Quinlan the power to assert his daughter's constitutional right to privacy.¹⁴⁹ The Court also granted him the power to choose the identity of Karen's doctors so that he could obtain another physician to terminate the life-support system should

¹³⁹ *Id.*

¹⁴⁰ Dr. Walter Sackett has proposed such legislation in the Florida House affirming a terminally ill patient's right to die. Vodiga, *supra* note 63, at 17. See generally RUSSELL, *supra* note 15, at 334-35.

¹⁴¹ See YOUR DEATH WARRANT? 132 (J. GOULD AND LORD CRAIGMYLE eds. 1971) [hereinafter cited as WARRANT?]

¹⁴² See John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971).

¹⁴³ 137 N.J. Super. at 251, 348 A.2d at 814.

¹⁴⁴ *Id.* at 267, 348 A.2d at 823. The New Jersey Supreme Court did not address itself to this question.

¹⁴⁵ *Id.* at 266, 348 A.2d at 822.

¹⁴⁶ *Id.* at 250, 348 A.2d at 814.

¹⁴⁷ Courts have not given legal significance to the concept of a "living will" despite the arguments offered by many of its advocates. See Moore, *supra* note 111, at 335; 44 IND. L. J., *supra* note 127. Cf. Vodiga, *supra* note 63, at 10, criticizing the "living will" concept as being too vague and not a statement of present intent.

¹⁴⁸ 137 N.J. Super. at 260, 348 A.2d at 819.

¹⁴⁹ 70 N.J. at 34, 41; 355 A.2d at 660, 664.

her treating physician, Dr. Morse, continue to refuse to take these measures.¹⁵⁰ The Court, further, concluded that Mr. Quinlan had proved his competency to serve in Karen's best interests¹⁵¹ and therefore conferred her guardianship on him.¹⁵² Many writers and several Bills support the decision to allow a parent to give consent to withdraw treatment from a cerebrally dead patient.¹⁵³ One writer has even created a separate classification for this type of euthanasia; rather than regard such consent as involuntary euthanasia, she categorizes it as non-voluntary.¹⁵⁴ The basis for allowing parental consent where a patient has experienced irremedial brain damage appears to be an insistence that quality of life must be taken into account.¹⁵⁵ In addition, the parents are most familiar with their child's wishes¹⁵⁶ and they are the ones to share her burden.¹⁵⁷ Advocates of this position argue, moreover, that guardians of an incompetent patient are able to give consent to allow organ donations from their ward and to permit him or her to undergo non-therapeutic experimental procedures.¹⁵⁸ Similarly, a guardian can consent to institutionalizing his ward for life.¹⁵⁹

The New Jersey Supreme Court, however, rested its decision on essentially two lines of reasoning: one, the Court had no doubt that were Karen miraculously lucid for a moment that she would make this request for herself,¹⁶⁰ and two, that the only practical way to preserve for Karen her right to privacy was to allow Mr. Quinlan and his family "... to render

¹⁵⁰ *Id.* at 55, 355 A.2d at 671.

¹⁵¹ *Id.* Disagreeing with the lower court on this point, the New Jersey Supreme Court held that while Mr. Quinlan naturally felt grief, he had sufficient "strength of purpose and character" to qualify him as her guardian. The court rejected the idea that his feelings would distort his judgment. See 137 N.J. Super. at 269-70, 348 A.2d at 824. For a history of Mr. Quinlan's decision to seek relief in the courts, see 137 N.J. Super. at 248, 348 A.2d at 813.

¹⁵² 70 N.J. at 55, 355 A.2d at 671.

¹⁵³ See RUSSELL, *supra* note 15, at 179, 229, 274-75; Wilson, *supra* note 84, at 194; Fletcher, *The Patient's Right to Die*, in EUTHANASIA AND THE RIGHT TO DIE 65 (A. Downing ed. 1969); Kutner, *supra* note 127; Moore, *supra* note 111, at 327. Professor Moore takes this position but adds a safeguard against avaricious relatives by demanding a forfeiture of 25% of that relative's share in the patient's estate. Moore, note 111, at 335. Some euthanasia bills allow consent by next of kin. See 3 HOFSTRA L. REV., *supra* note 21, at 127.

¹⁵⁴ RUSSELL, *supra* note 15, at 230.

¹⁵⁵ See Kirvin, *supra* note 84, at 29.

¹⁵⁶ See Robertson, *supra* note 45, at 262.

¹⁵⁷ Parents of defectively born infants who are kept on life-support systems over a long period of time incur great medical costs and suffer a higher than average rate of divorce and suicide. See Benfield, *supra* note 23.

¹⁵⁸ See, e.g., Cantor, *supra* note 56, at 86. See generally Annot., 35 A.L.R. 3d 692 (1971).

¹⁵⁹ See RUSSELL, *supra* note 15, at 229.

whether she would exercise it in these circumstances."¹⁶¹ The Court seems to base the first of its rationales on the few statements Karen herself had previously made, which in themselves were not sufficiently probative,¹⁶² and on the Court's interpretation of what the majority of people in our society would choose to do if placed in the situation of never returning to a cognitive life.¹⁶³

their best judgment, subject to the qualifications hereinafter stated, as to

It is interesting to note that in Ohio, the standing to assert the right to privacy is not restricted to the injured party.¹⁶⁴ In *Friedman v. Cincinnati Local Joint Executive Bd.*,¹⁶⁵ a restaurant owner who was the target of union antagonism was granted standing to assert his customers' right to privacy. Besides allegedly instigating several incidents involving stench bombs and stone-shattered glass, defendants placed a motion picture camera at the entrance of plaintiff's restaurant and proceeded to take pictures of customers entering and leaving the premises. The Court said,

... one must concede that persons occupying prominent positions in public life and government impliedly grant the right to publish their pictures. Private individuals likewise may do so, either expressly or by tacit consent, but an ordinary individual, in our opinion and according to what we believe to be the better principle, has a right to insist upon his privacy.¹⁶⁶

Here, whether or not the customers would have actually considered defendant's acts a violation of their right to privacy, the Court implicitly measured defendant's acts against how a reasonable person would feel in this situation and issued a permanent injunction against defendant's hostile acts.¹⁶⁷ Although *Friedman* may be distinguished from the facts in the *Quinlan* case in that the defendants in *Quinlan* have not purposely tried to injure Mr. Quinlan in any way (financially or otherwise), the fact that a plaintiff may rely on an objective test for consent or lack of consent to an invasion of a third party's right to privacy might well buttress the support in Ohio for the position taken by the New Jersey Supreme Court in the *Quinlan* case.

There are, however, some very strong countervailing arguments to

¹⁶¹ *Id.* at 41, 355 A.2d at 664.

¹⁶² *Id.* See also 137 N.J. Super. at 248, 348 A.2d at 814.

¹⁶³ 70 N.J. at 42, 355 A.2d at 664.

¹⁶⁴ 20 Ohio Op. 473 (C.P. Hamilton County 1941), *rev'd on other grounds*, 86 Ohio App. 189, 90 N.E.2d 447 (1941).

¹⁶⁵ *Id.*

¹⁶⁶ 20 Ohio Op. at 477.

the position taken by the New Jersey Supreme Court. The most compelling of these propositions is that it is unconstitutional to allow another party to assert an individual's "inalienable rights."¹⁶⁸ According to Article I, Section I of the Ohio Constitution, "All men . . . have certain inalienable rights, among which are those of enjoying and defending life and liberty . . ."¹⁶⁹ Because the right to life is non-transferable, the consent of the victim of a homicide is immaterial;¹⁷⁰ likewise, a humanitarian motive does not excuse the offense.¹⁷¹ The New Jersey Supreme Court, in rendering its decision in the *Quinlan* case, did not address itself to this issue despite the fact that there exists a similar clause in the New Jersey Constitution.¹⁷² One wonders how that Court could have met this argument and still render its decision as it did.¹⁷³

Others have taken issue with allowing the family of a critically ill incompetent to direct the decision to discontinue the use of the respirator.¹⁷⁴ The Superior Court of New Jersey, for example, felt that conflicts within Mr. Quinlan would distort his judgment on this question;¹⁷⁵ the Court considered it impossible for her father to maintain a position of disinterestedness.¹⁷⁶ Even if this were not so, one law review article asserted there would be the problem of egocentricity, of not being able to know what was in another person's mind.¹⁷⁷ Although parents may terminate a dependency relationship with their child, this does not mean that they may choose death for that child.¹⁷⁸ The Superior Court of New Jersey considered the

¹⁶⁸ See Hopperton, *supra* note 86. Similarly, with defective newborns, Robertson affirms, "Although the law clothes the defective newborn with a right to life and a corresponding duty of care from those in certain relations with him, many people think that that right ends when it conflicts with the interests of parents, the medical profession, and the infant's own potential for full development." Robertson, *supra* note 45, at 268.

¹⁶⁹ OHIO CONST. art I, §1.

¹⁷⁰ See *State v. Moore*, 25 Iowa 128 (1868); *Martin v. Commonwealth*, 184 Va. 1009, 37 S.E.2d 43 (1946).

¹⁷¹ See, e.g., *People v. Roberts*, 211 Mich. 187, 178 N.W. 690 (1920). See also cases cited note 105 *supra*.

¹⁷² 70 N.J. at 19 n.1, 355 A.2d at 652 n.1.

¹⁷³ Perhaps the Court would have insisted that it was not transferring Karen's right to life to her father for his determination, but was merely using Mr. Quinlan to illuminate Karen's attitudes about discontinuing a life-support system when a person is deemed to have a non-functioning cerebrum along with other physical complications.

¹⁷⁴ See 137 N.J. Super. at 260, 348 A.2d at 819, 824. See also Robertson, *supra* note 45, at 263.

¹⁷⁵ 137 N.J. Super. at 270, 348 A.2d at 824. But see notes 151-54, 157-61 and accompanying text *supra*.

¹⁷⁶ 137 N.J. Super. at 261, 348 A.2d at 819. Robertson is also skeptical of a proxy's claim of impartiality. Robertson, *supra* note 45, at 254.

¹⁷⁷ Robertson, *supra* note 45, at 254.

¹⁷⁸ Robertson was talking about parents of severely brain damaged children, but an analogy to the facts in the *Quinlan* case may be made. Robertson, *supra* note 45, at 263.

question of terminating Karen's respirator to be a purely medical decision,¹⁷⁹ where Karen had not made sufficiently clear her views on this issue.¹⁸⁰ The Court was not so certain that Karen would indeed prefer death.¹⁸¹ The lower court, therefore, in *Quinlan*, chose continuing Karen's life to be in her best interests.¹⁸²

Although a parent may consent to treatment for his child,¹⁸³ he may only consent to treatment that is beneficial for that child.¹⁸⁴ Similarly, certain rights have been held to be purely personal in nature; a husband or a parent of a pregnant woman, for example, may not consent or refuse consent to her having an abortion.¹⁸⁵ The right to privacy is considered to be a personal right in Ohio¹⁸⁶ and the ability to sue for the invasion of that right is extinguished at the injured party's death.¹⁸⁷ A final argument against allowing a parent to assert his comatose critically ill daughter's rights is what has been named the "wedge" argument;¹⁸⁸ as one writer asserts, "Even if the judgment occasionally may be defensible, the potential danger of quality-of-life assessments may be a compelling reason for rejecting this rationale for withholding treatment."¹⁸⁹ Mr. Quinlan's claim of possessing independent rights as a parent was rejected by both of the New Jersey courts.¹⁹⁰ The only time standing is granted to a parent for relief in *propria persona* is where a question involving continuing life styles has been involved.¹⁹¹

¹⁷⁹ 137 N.J. Super. at 260, 348 A.2d at 819.

¹⁸⁰ *Id.* at 260, 265, 348 A.2d at 819, 822.

¹⁸¹ *Id.* In the parallel situation of a severely defective newborn, Robertson questioned, "But in what sense can the proxy validly conclude that a person with different wants, needs, and interests, if able to speak, would agree that such a life were worse than death?" Robertson, *supra* note 45, at 254.

¹⁸² 137 N.J. Super. at 258, 348 A.2d at 819, 822. Generally, where a patient is unconscious, the law gives constructive consent to physicians to preserve that patient's life. See Gurney, *supra* note 15, at 244; 44 IND. L. J., *supra* note 131, at 547. See generally 36 ALBANY L. REV., *supra* note 15.

¹⁸³ See notes 158-59, and accompanying text *supra*.

¹⁸⁴ See Horan, *supra* note 53, at 81.

¹⁸⁵ Planned Parenthood of Central Missouri v. Danforth, 96 S. Ct. 2831 (1976).

¹⁸⁶ 10 Ohio Op. 338, 341.

¹⁸⁷ Young v. That Was The Week That Was, 423 F.2d 265 (6th Cir. 1970).

¹⁸⁸ Advocates of the wedge argument include: Hopperton, *supra* note 89; Kamisar, *Euthanasia Legislation*, in EUTHANASIA AND THE RIGHT TO DEATH 85 (A. Downing ed. 1969); St. Martin, *Euthanasia: The Three-In-One Issue*, 27 BAYLOR L. REV. 62 (1975). But see Moore, *supra* note 111, at 337-38; Williams, *supra* note 112.

¹⁸⁹ Robertson, *supra* note 45, at 255.

¹⁹⁰ 70 N.J. at 42, 355 A.2d at 664; 137 N.J. Super. at 266, 348 A.2d 822.

¹⁹¹ *Id.*

A guardian, in Ohio, is required to provide necessary maintenance for his ward.¹⁹² Furthermore, proper maintenance includes nursing and medical services.¹⁹³ Failure to supply these resources and failure to act in the best interest of his ward would probably constitute abandonment and the forfeiture of a parent's rights as a guardian.¹⁹⁴ In addition, when the relationship of guardian-ward terminated, a former ward could bring an action against him.¹⁹⁵ If the family consented to a physician's withholding treatment, it would be unable to bring suit against the doctor or the hospital for wrongful death.¹⁹⁶ Yet, such consent would not bar a suit by other relatives of the deceased.¹⁹⁷ The parents or guardian could also face criminal charges.¹⁹⁸ They would be liable as a principal to aggravated murder and to murder.¹⁹⁹ Even if the prosecutor considered the family to be under a great emotional weight, they could still be liable for voluntary manslaughter.²⁰⁰ According to Section 2903.03 of the Ohio Revised Code, "No person, while under extreme emotional stress brought on by serious provocation reasonably sufficient to incite him into using deadly force, shall knowingly cause the death of another."²⁰¹ Therefore, even a parent in the position of Mr. and Mrs. Quinlan could not consent to causing Karen's death without fear of prosecution.

V. OHIO'S INTERESTS

What are Ohio's duties and powers to preserve Karen's life? According to the federal constitution, the state may not deprive a person of his life without due process of law.²⁰² The Ohio Constitution specifically enunciates a person's inalienable right to life.²⁰³ Therefore, although the state has the

¹⁹² OHIO REV. CODE ANN. §2111.13(B) (Page 1975).

¹⁹³ *In re Burns*, 79 N.E.2d 234 (Ohio Ct. App. 1948).

¹⁹⁴ *See Clark v. Bayer*, 32 Ohio St. 299 (1877).

¹⁹⁵ *Kreglow v. Russell*, 44 Ohio L. Abs. 385, 65 N.E.2d 269 (Ct. App. 1944).

¹⁹⁶ *See Sharp, supra* note 61, at 98. Any claim under wrongful death would be very difficult to maintain not only on the basis of estoppel, but also on the rationale that this action requires that the plaintiff establish pecuniary loss by such death and that plaintiff show that "but for" defendant's acts, decedent would have lived. Address by T. Scanlon, attorney, Conference, *supra* note 14.

¹⁹⁷ *See Horan, supra* note 53, at 82.

¹⁹⁸ *See* notes 96-99 and accompanying text *supra*.

¹⁹⁹ *Id.*

²⁰⁰ OHIO REV. CODE ANN. §2903.03 (Page Supp. 1975).

²⁰¹ OHIO REV. CODE ANN. §2903.03(A) (Page Supp. 1975).

²⁰² U.S. CONST. amends. V, XIV.

²⁰³ OHIO CONST. art. I §1.

power to end a person's life, it may only do so in very limited situations where the person has received sufficient constitutional safeguards.

Where a patient is an incompetent, the courts have authority to act in his or her best interests.²⁰⁴ Generally, this power to act has been called the doctrine of substitute judgment.²⁰⁵ It has also been referred to as *parens patriae*, "... the sovereign power of guardianship over persons under disability."²⁰⁶ In addition, the duty of the court to order medical treatment has been based on the imminent danger of death theory.²⁰⁷ Where statutory provisions do not specifically confer this power upon the court,²⁰⁸ the court may nevertheless find the power to act under its broad equity jurisdiction.²⁰⁹

The courts have disagreed on the question of forcing treatment on a competent adult whose life is in danger.²¹⁰ Where they have ordered blood transfusions or other medical care over the competent adult's wishes, such action has been based on several theories. It has been premised on a state statute allowing the state to intervene to prevent suicides,²¹¹ on the grounds of "actual" consent,²¹² and on the competent adult's duty to a third person or to society.²¹³ While there are conflicting opinions with regard to a competent adult's refusal of medical treatment, the courts have rejected a parent or a wife's ability to deny blood transfusions and surgery for their

²⁰⁴ See 137 N.J. Super. at 254, 348 A.2d at 816.

²⁰⁵ *Id.*

²⁰⁶ Address by the Honorable William Kannel, Judge, Summit County (Ohio) Juvenile Court, Conference, *supra* note 14.

²⁰⁷ BLACK'S LAW DICTIONARY 1269 (4th ed. 1968). *Parens patriae* has been invoked to grant medical treatment over parents' objections. 10 CALIF.-WESTERN L. REV., *supra* note 15, at 617. In the *Quinlan* case, the Superior Court invoked this doctrine and differentiated the situation of a competent adult who is asserting control over the treatment of his body. 137 N.J. Super. at 265, 348 A.2d at 822.

²⁰⁸ In Ohio, the Juvenile Code authorizes the court to protect a child's rights. OHIO REV. CODE ANN. §2151.33 (Page 1968).

²⁰⁹ See, e.g., *In re Clark*, 21 Ohio Op. 2d 86, 87, 185 N.E.2d 128, 129 (C.P. Lucas County 1962).

²¹⁰ See 70 N.J. at 35, 355 A.2d at 661. See also Annot. 9 A.L.R. 3d 1393 (1966).

²¹¹ See RUSSELL, *supra* note 15. The New Jersey Supreme Court, in the *Quinlan* case, distinguished *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971), from the instant case on the basis that Karen would undoubtedly choose death. 70 N.J. at 39, 355 A.2d at 663.

²¹² See Moore, *supra* note 111, at 327, citing *Powell v. Columbia Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S. 2d 450 (Sup. Ct. 1965).

²¹³ See 7 HOUSTON L. REV., *supra* note 137, at 667-68.

child²¹⁴ or incompetent husband.²¹⁵ In *In re Clark*,²¹⁶ an Ohio Common Pleas Court ordered blood transfusions to be given to a three-year-old child over his parent's religious objections.²¹⁷ The Court held that a parent's religious belief must be ignored when it collided with their child's right to life,²¹⁸ and while parents "... may under certain circumstances, deprive him of his liberty or his property, under no circumstances, with or without due process, with or without religious sanction may they deprive him of his life!"²¹⁹

In an emergency situation, a person is deemed to have given constructive permission to receive medical treatment.²²⁰ In Ohio, there is also implied consent to perform an operation or render other medical treatment where there is a life or death situation.²²¹ An emergency situation was found in Ohio even where death was not imminent, but where medical opinion was such that without a blood transfusion, the patient *might* die.²²² Moreover, a physician may have a duty to disregard a patient's wishes,²²³ while a patient may knowingly refuse treatment, he may not be allowed to demand that a doctor commit malpractice.²²⁴ Once a patient has entered the hospital, his course of treatment is a medical decision.²²⁵

While the courts have allowed non-therapeutic operations to be performed on an incompetent with his family's consent,²²⁶ they may only grant such permission where it is in the best interests of the incompetent.²²⁷ Where the judge has not acted with the incompetent's best interests in

²¹⁴ See generally Annot., 9 A.L.R. 3d 1391, 1393 (1966); 3 U.S.F.V. L. REV., *supra* note 135, at 104.

²¹⁵ See RUSSELL, *supra* note 15, at 39, citing the *Bettman* case, wherein the Supreme Court of New York held that the patient's wife was not allowed to refuse to grant permission to permit surgery on her husband for a new pacemaker.

²¹⁶ 21 Ohio Op. 2d 86, 185 N.E.2d 128 (C.P. Lucas County 1962).

²¹⁷ *Id.*

²¹⁸ *Id.* at 90, 185 N.E.2d at 132.

²¹⁹ *Id.* at 89, 185 N.E.2d at 131.

²²⁰ See Gurney, *supra* note 15, at 244.

²²¹ *Urbanek v. Stotter*, 5 Ohio L. Abs. 736 (Ct. App. 1926).

²²² 21 Ohio Op. 2d at 88, 185 N.E.2d at 130.

²²³ See Gurney, *supra* note 15, at 244.

²²⁴ See generally Annot., 9 A.L.R. 3d 1391, 1395-96 (1966).

²²⁵ *Id.* at 1396.

²²⁶ See Cantor, *supra* note 56, at 86.

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²²⁷ 137 N.J. Super. at 254, 348 A.2d at 816.

mind, he has been held liable for his actions.²²⁸ In *Wade v. Bethesda Hospital*,²²⁹ in which a judge ordered the sterilization of a feeble-minded girl, not only was the judge held liable for acting outside the scope of his authority, but the doctor who performed the operation, the hospital at which it was performed, and the employees of the County Children's Services Board were held *not* immune from liability.²³⁰

Finally, the state possesses police powers which pertain to safety, health, morals, and general welfare of the public.²³¹ If a decision to end the life of an incompetent adult would establish detrimental precedent for allowing the courts to distinguish among different qualities of existence, the state's interest in preserving a life such as Karen's may be regarded as paramount.²³²

CONCLUSION

In 1906, Ohio became the first English speaking political unit to introduce a Euthanasia Bill,²³³ but Ohio's efforts in this regard were confined to a competent adult with a terminal illness.²³⁴ The Bill did not focus on the situation of a critically ill incompetent person and, in fact, no attempt to implement involuntary euthanasia has been made in the Ohio legislature to date.

It is questionable whether the Ohio legislature would have the power to enact an involuntary euthanasia bill without first amending its constitution. While the right to privacy may under certain circumstances be asserted by a third person under Ohio case law,²³⁵ according to the Ohio Constitution the right to life is an inalienable right.²³⁶ Therefore, where there is

²²⁸ See, e.g., *Wade v. Bethesda Hosp.*, 337 F. Supp. 671 (S.D. Ohio 1971). Cf. *In re Simpson*, 88 Ohio L. Abs. 193, 180 N.E.2d 206 (P. Ct. Zanesville County 1962), in which the same judge, defendant Gary, ordered sterilization of an incompetent. This act was criticized by the court in *Wade* and the court reasoned that efforts in the Ohio legislature to authorize sterilization of the feeble-minded have met with public disfavor. 337 F. Supp. at 674.

²²⁹ 356 F. Supp. 380 (S.D. Ohio 1973).

²³⁰ *Id.*

²³¹ See *Lochner v. New York*, 198 U.S. 45 (1905).

²³² See 137 N.J. Super. at 255-56, 348 A.2d at 817.

²³³ See RUSSELL, *supra* note 15, at 60. This bill was defeated and received much adverse publicity. For a discussion of other states' and other countries' proposed euthanasia bills, see MANNES, *supra* note 127, at 64-65, 98-99, 128; RUSSELL, *supra* note 15, at 188-97, 255-75, 334-35; WARRANT?, *supra* note 141; Louisell, *supra* note 49; Williams, *supra* note 112.

²³⁴ See RUSSELL, *supra* note 15, at 60-61.

²³⁵ See notes 164-67 and accompanying text *supra*.
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²³⁶ See note 169 *supra*.

insufficient evidence of how a person would have asserted this right for him or herself, as is the situation in the *Quinlan* case, the courts must presume, under present Ohio law, that Karen would choose to live.

The crucial decision that the legislature must make is on the issue of what constitutes legal death. In making this determination, it is exceedingly important that the legislature adopt a definition of death that embraces the attitudes of physicians and of the general public. Under House Bill 1112,²³⁷ which accepts brain death as the criteria for determining time of death, a patient like Karen would be considered a live person with an inalienable right to life. The brain definition is the most acceptable definition of death to many medical authorities²³⁸ and is the one preferred by the author of this essay. It makes provision for organ transplants while, at the same time, it refuses to differentiate among different qualities of life. All of life is considered valuable unless an individual himself deems otherwise. This attitude does not refuse to recognize the plight of the family in circumstances similar to the *Quinlan* case. This burden, however, must be assuaged by means other than ordering another's death. Alternatives such as a national or state health insurance plan and counselling services, similar in form to that of Alcoholics Anonymous, for the families of severely brain damaged persons are possible ways to lessen some of the economic and emotional problems besetting these families.

If, however, society and the medical community truly believe that all Karens would definitely seek a natural death or that, in fact, Karen is not alive, the legislature must adopt cerebral death as the legal definition of death. If such were the standard, when a patient like Karen had a cerebrum which was not functioning, she would be considered legally dead and would be removed from all health care. Should such a definition be contemplated, however, great attention should be given to re-evaluating society's commitments to brain damaged individuals; any decision made regarding a patient like Karen would have equal application to these persons.

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²³⁷ See note 38 *supra*.
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²³⁸ See generally Kilway, *supra* note 15.

