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ARTICLES

THE "SMALL BEGINNINGS" OF EUTHANASIA: EXAMINING THE EROSION IN LEGAL PROHIBITIONS AGAINST MERCY-KILLING

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and

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The day will come when people will be able to carry a card, notarized and legally executed, which explains that they do not want to be kept alive beyond the humanum point, and authorizing the ending of their biological processes by any of the methods of euthanasia which seems appropriate. Suicide may or may not be the ultimate problem of philosophy, as Albert Camus thought it is, but in any case it is the ultimate problem of medical ethics.¹

Rev. Joseph Fletcher (1973)

* Surgeon General, United States Public Health Service, Deputy Assistant Secretary for Health, United States Department of Health and Human Services; formerly Surgeon-in-Chief, Children's Hospital of Philadelphia. Dr. Koop wishes to dedicate this article to the memory of Dr. Leo Alexander, a neuropsychiatrist and professor at Tufts University, who died on July 20, 1985. The importance of Dr. Alexander's work is briefly reviewed in note 10, *infra*.

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1. J. FLETCHER, *TO LIVE AND TO DIE: WHEN, WHY, AND HOW* 122 (1973). Fletcher's *humanum* point is that point beyond which the rational faculty of man is lost; in physiological terms, the loss of function in the cerebral cortex. *Id.* at 115. The *humanum* point, therefore, is to be distinguished from the concept of "whole brain death," or irreversible loss of all functions of the entire brain, including the brain stem, which is the accepted standard for diagnosis of death by neurological criteria. *See infra* notes 26-35 and accompanying text.

A brief excursion into Fletcher's arguments on behalf of legalized euthanasia is warranted by the dedication of this essay to Dr. Leo Alexander. Fletcher dismisses out of hand all opposing arguments which recall the outcome of this century's most ambitious foray into legalized euthanasia.

Social and legal trends indicate that the present generation of Americans will decide whether Fletcher's prophecy comes to pass. The public debate initiated in the case of Karen Quinlan² has now gone beyond the proposition of allowing the terminally ill to "die well." Now, the question is what to do about the "biologically tenacious" individuals who simply do not die within an acceptable time frame, as determined by their families or society.³ Increasing support is seen for the legalization of acts taken (or not taken) with the direct intent of causing the death of the patient. In 1986, legislation will be introduced to permit the "living will" to be utilized, not only to direct the removal of life-prolonging medical treatment, but to permit the administration by physi-

"Vestigial last-ditch pro-vitalists still mumble threateningly about 'what the Nazis did,' but in fact the Nazis never engaged in euthanasia or mercy-killing; what they did was merciless killing, either genocidal or for ruthless experimental purposes." *Id.* at 113-14. Fletcher shows little respect for his opponents or their arguments; more importantly, he distorts the historical record upon which these arguments are based. As Dr. Alexander painstakingly chronicled after his experience at the Nuremberg trials, the German experiment with euthanasia was well in place years before Hitler came to power. Alexander, *Medical Science Under Dictatorship*, 241 *NEW ENG. J. MED.* 39 (1949). "It is rather significant that the German people were considered by their Nazi leaders more ready to accept the exterminations of the sick than those for political reasons. It was for that reason that the first extermination of the latter group were carried out under the guise of sickness." *Id.* at 41. See also R. LIFTON, *THE NAZI DOCTORS* 45-51 (1986).

A prevalent response to such evidence is that it "can't happen here." The rejoinder of Professor Yale Kamisar to this argument is a powerful reminder of the price a society must pay for such security.

Well, maybe it cannot, but no small part of our Constitution and no small number of our Supreme Court opinions stem from that *it can happen here unless we darn well make sure that it does not* by adamantly holding the line, by swiftly snuffing out what are or might be small beginnings of what we do not want to happen here. To flick off . . . the fears about legalized euthanasia as so much nonsense, as a chimerical "parade of horrors," is to sweep away much of the ground on which all our civil liberties rest.

Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 *MINN. L. REV.* 969, 1038 (1958).

2. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

3. [A] denial of nutrition may in the long run become the only effective way to make certain that a large number of biologically tenacious patients actually die. Given the increasingly large pool of superannuated, chronically ill, physically marginal elderly, it could well become the nontreatment of choice . . . [B]ecause we have now become sufficiently habituated to the idea of turning off a respirator, we are psychologically prepared to go one step further.

Callahan, *On Feeding the Dying*, *HASTINGS CENTER REP.*, Oct. 1983, at 22.

cians of "aid in dying," such as the injection of lethal drugs.⁴ In the courts, patients, families, physicians and hospitals wrangle over whether the withdrawal of life-prolonging treatment can be extended to include mechanical means of nutrition and hydration.⁵ The public policy debate over the provi-

4. A claim that such legislation would be drafted and introduced in three states—Arizona, California, and Florida—appeared in the Autumn, 1985 edition of *Hemlock Quarterly*, the newsletter of the Hemlock Society. The following edition of *Hemlock Quarterly* set forth a series of sweeping amendments to the California Natural Death Act, CAL HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985), and to relevant portions of the state Penal Code. The essence of the amendments would be to ease the procedural requirements for executing a directive to have life-sustaining procedures withdrawn or withheld, and to permit a request for direct "aid-in-dying" to be carried out by a physician. "Aid-in-dying" is defined in the Hemlock proposal as "any medical procedure that will swiftly, painlessly and humanely terminate the life of the qualified patient." A request for mercy-killing under this proposal could be made directly by a competent patient, or be executed in an advance directive and carried out in the event that the patient has lost the ability to communicate. Amendments to the Penal Code would grant immunity to any homicidal act carried out under a directive to withdraw or withhold medical treatment, or any directive to provide "aid-in-dying."

Hemlock is the most aggressive of the American organizations which promote euthanasia, being the only one that openly espouses the legalization of active euthanasia. For a discussion of the definition of euthanasia, and the distinctions between "active" and "passive" euthanasia, see *infra* notes 12-25 and accompanying text. The founder of Hemlock, Derek Humphry, is a former British journalist who assisted in the suicide death of his first wife, who was suffering from a terminal illness. D. HUMPHRY, *JEAN'S WAY* (1981). Two other American groups are affiliated with the "euthanasia" or "right to die" movement: the Society for the Right to Die (SRD) and Concern for Dying (CFD). SRD was originally incorporated in 1938 as the Euthanasia Society of America, and sponsored legislation at that time which would have decriminalized the practice of active, voluntary euthanasia. Kamisar, *supra* note 1, at 978-79. SRD assumed its current name in the mid-1970's, in an attempt to avoid the controversy engendered by the term "euthanasia." P. MARX, *AND NOW EUTHANASIA* 21 (1985); *EUTHANASIA NEWS*, Feb. 1975, at 1 (Publication of Euthanasia Education Council). SRD remains closely affiliated, however, with the World Federation of Right to Die Societies, an international organization of groups which espouse active, voluntary euthanasia. See *World Right to Die Newsletter* (May 1984). (President of SRD served as president of the World Federation for four years.) CFD, also a member of the World Federation, was formerly known as the Euthanasia Education Council, and serves an educational mission, including the dissemination of "living Wills." See P. MARX, *supra*, at 23.

5. See, e.g., *In re Conservatorship of Pritchard*, No. 80125 (Cal. Super. Ct., San Mateo County, filed May 17, 1985) (petition of husband to obtain withdrawal of life-support, including nutrition and hydration, from wife, 45, alleged to be in a persistent vegetative state); *Brophy v. New England Sinai Hosp., Inc.*, No. 85E0009-G1 (Mass. Probate Ct., Norfolk, Oct.

sion of medical treatment to the elderly and the terminally ill is now, correctly in our view, seen as a debate over euthanasia as a means of "medical management" to meet the personal, social, and financial pressures that are placed upon the health care professions in the care of the chronically ill.⁶

These pressures have grown in the past decade, and will accelerate in the decades to come. America is aging more rapidly than at any time in her history. Modern health care, especially through its technological advances, has expanded our life expectancies, but cannot deliver affordable, life-affirming care to the long-term elderly and disabled. The potential impact of these factors upon public policy may be illustrated by comparison to another medico-legal controversy of recent vintage. Each year, approximately 50,000 infants are born with life-threatening handicaps,⁷ and thus, are potentially subject to the "Baby Doe" amendments made to the federal child abuse statute.⁸ By the year 2000, in comparison, there will be 35 million Americans over the age of sixty-five, and by the year 2020, that number will soar to over 50 mil-

21, 1985) *rev'd in relevant part*, No. 4152 (Mass. Sup. Jud. Ct. Sept. 11, 1986) (petition of wife of 48-year-old man found to be in persistent vegetative state to direct the withdrawal of a gastrostomy tube); *In re Jobs*, No. C-4971-85E (N.J. Super. Ct. Ch. Div., Morris County, Apr. 23, 1986) (granting petition by husband of severely and permanently brain-damaged woman, 30 years old, that a jejunostomy tube providing nutrition and hydration to her be removed). The *Pritchard* case reached a curious resolution when Dr. Ronald Cranford, an expert neurologist called by plaintiff, disputed the claim that Mrs. Pritchard was in a persistent vegetative state (PVS), and diagnosed her as "profoundly demented." The basis for the distinction is that Mrs. Pritchard retains some measure of cortical function; she is not, however, diagnosed as having a hope for recovery. *San Jose Mercury News*, Dec. 14, 1985, at B1. In the *Jobs* case, there was controversy over the precise neurological condition of the patient, although there is agreement that there is very little hope for recovery. *See infra* notes 136-39 and accompanying text.

6. Horan, *Euthanasia as a Form of Medical Management*, in *DEATH, DYING, AND EUTHANASIA* 196 (2d ed. 1980).

7. This figure is probably a high estimate. Of the 3.5 million births annually in the United States, approximately one percent are of infants weighing 1500 grams or less, and two percent have some form of birth defect, which can range from mild to life-threatening. Assuming that virtually all infants in the first category are at risk due to low birth weight, and that a significant number of infants fall into both categories, the estimate of 50,000 is derived. Source: National Center for Health Statistics, Department of Health and Human Services.

8. Child Abuse Amendments of 1984, Pub. L. No. 98-457, 98 Stat. 1749 (to be codified in scattered sections of 42 U.S.C.). *See also* 45 C.F.R. § 1340.15 (1985).

lion.⁹ Each of these elderly persons may at some time require extensive (and expensive) medical care. In short, for every potential Baby Doe, there will be approximately 15,000 "Granny Does." The impact of this demographic fact is likely to wield greater influence on the debate over euthanasia than jurisprudential concerns over the appropriate extent of personal liberty, patient autonomy, and the state interest in preserving life.

This article will examine whether the legislation and court decisions which have addressed these problems in recent years have strengthened or weakened existing legal prohibitions against euthanasia. We will commence with a brief explanation of the legal definition of euthanasia. Our substantive discussion will concern three categories of legal developments: the legislative definition of death, legislation regarding the "living will," and recent judicial opinions. Within each of these categories, we will focus on a specific, representative development for our detailed analysis.

Our thesis is that changes in the obligation to provide medical treatment to seriously ill and incompetent patients have created a legal climate that is favorable to euthanasia, which is the *intentional* killing, by omission or direct action, of those whose lives are considered of insufficient value to maintain. The consequences of fostering such a climate were compellingly stated by the late Dr. Leo Alexander, a Boston psychiatrist and professor of medicine who died in 1985. Dr. Alexander served as a medical consultant at the war-crimes trials of physicians who participated in the atrocities of the Nazi regime in Germany. His witness to a depraved aspect of twentieth-century history is more salient in the America of 1986 than it was in the America of 1948.

Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started *from small beginnings*. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in

9. 1985 ANNUAL REPORT OF THE BOARD OF TRUSTEES, FEDERAL OLD-AGE AND SURVIVORS INSURANCE AND DISABILITY INSURANCE TRUST FUNDS, H.R. Doc. No. 46, 99th Cong., 1st Sess. 77 (1985).

this category was enlarged to encompass the socially unproductive, the ideologically unwanted, and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was *the attitude toward the nonrehabilitable sick*.¹⁰

The legal developments that have taken place in the past decade offer convincing evidence that American legal institutions in the 1980's are examining precisely the same question that was addressed so tragically by the legal profession in Germany in the 1920's: society's attitude towards those who are chronically sick and infirm. Leo Alexander knew that American law and medicine could not escape this dilemma, in

10. Alexander, *supra* note 1, at 44 (emphasis supplied).

Dr. Alexander died on July 20, 1985, at the age of 79. A native of Austria, he received his medical degree from the University of Vienna in 1929. He came to the United States in 1933 and held several medical positions in the Boston area, including one at Harvard Medical School, before being appointed associate professor of neuropsychiatry at Duke Medical School in 1941. World War II interrupted his academic career. His military service included time with the Eighth Air Force in England, and with an intelligence unit of the Seventh Army. He returned to Boston after his service in the military.

Dr. Alexander's contribution to the study of euthanasia grew out of his position after World War II as an aide to Office of Chief of Counsel for War Crimes at Nuremberg. Out of this work came studies of the social and psychiatric forces that corrupted the German medical profession during the Weimar Republic, and overran all of German society during the Nazi period. See Alexander, *The Socio-Psychologic Structure of the SS and the Criminalization of a Society*, 39 J. CRIM. L. & CRIMINOLOGY 298 (1948); *The Molding of Personality Under Dictatorship—The Importance of the Destructive Drives in the Socio-Psychological Structure of Nazism*, 40 J. CRIM. L. & CRIMINOLOGY 3 (1949); *War Crimes: Their Social-Psychological Aspects*, 105 AM. J. PSYCHIATRY 170 (1948); *Sociopsychologic Structure of the SS: Psychiatric Report of the Nürnberg Trials for War Crimes*, 59 ARCHIVES NEUROLOGY & PSYCHIATRY 622 (1948). Dr. Alexander's prolific writing was no doubt aided by his ability to converse with war crimes defendants as a native speaker of their mother tongue.

The socio-psychologic aspects of Nazi war crimes may seem of little relevance to the debate on the withdrawal of medical treatment in America in the 1980s. Alexander penetrated this curtain, however, by seeking the common sources of "beneficent" euthanasia and mass genocide, and tracing them to the "small beginnings" referred to in the quoted passages from *Medicine Under Dictatorship*. He was aware, at the end of his life, of the dynamic changes in American law and medical ethics that have occurred in recent years. In the last summer of his life, he suggested that "it is much like Germany in the 20s and 30s. The barriers against killing are coming down." Hentoff, *Barriers Against Killing Are Coming Down*, National Right to Life News, Apr. 10, 1986 (reprinted from Washington Post).

part because, even forty years ago, the signs of a utilitarian medical ethic were present in our society.

The killing center is the *reductio ad absurdum* of all health planning based only on rational principles and economy and not on humane compassion and divine law. To be sure, American physicians are still far from the point of thinking of killing centers, but they have arrived at a danger point in thinking, at which likelihood of full rehabilitation is considered a factor that should determine the amount of time, effort and cost to be devoted to a particular type of patient on the part of the social body upon which this decision rests. At this point Americans should remember that the enormity of a euthanasia movement is present in their own midst.¹¹

In the past decade, a reawakened euthanasia movement has achieved a great deal in changing the stance of American law towards the terminally ill, the chronically comatose, and more importantly, the desirability of hastening death for such medically dependent patients. We hope by this article to serve the memory of Leo Alexander by identifying the sources and extent of this change in the law, and to offer proposals whereby greater erosion in our law against euthanasia may be averted.

I. A MEDICO-LEGAL DEFINITION OF EUTHANASIA

In 1958, the year Professor Yale Kamisar published *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*,¹² there was no confusion as to the subject matter of the debate. In fact, Kamisar simply used the terms "euthanasia," "voluntary euthanasia," "involuntary euthanasia" and "mercy-killing" as if there were no need of further definition.¹³ Kamisar's critics found much to fault in his arguments, but did not criticize his terminology.¹⁴

There is no such luxury in the current discussion. Instead of a clear-cut discussion of whether or not voluntary euthanasia ought to be legalized, we are confronted with

11. Alexander, *supra* note 1, at 46-47.

12. Kamisar, *supra* note 1.

13. Kamisar's principle object was not to define euthanasia, since the proponents of euthanasia at that time were more forthcoming in their objectives than they are today.

14. See, e.g., Williams, "Mercy-Killing" Legislation—A Rejoinder, 43 MINN. L. REV. 1 (1958).

questions such as the "right to die" and "natural death" and "death with dignity." In part, this change reflects the evolution of social concern and the medical context of the debate. In the first three decades in which euthanasia societies were active in the United States, the profile of the average candidate for euthanasia was that of a terminally ill patient, afflicted with a chronic disease such as cancer, and suffering from intractable pain, not amenable to relief by medication.¹⁵ The solution proposed by the proponents of voluntary euthanasia was direct intervention to end the life of the patient.

Much has happened in the last twenty-five years to change that picture. More than any other event, the case of Karen Quinlan shifted the focus in the euthanasia debate from the dying cancer patient to the chronically impaired and bedridden individual, and from a direct, life-taking intervention to the withholding or withdrawal of life-prolonging treatments.¹⁶ As a result, the current debate concerns not only the alleged desire of certain patients to kill themselves or be killed by active means, but also the wish to die without the intervention of life-prolonging measures.¹⁷

Regardless of the condition of the patient, however, the fundamental elements of euthanasia remain the same. We utilize this term to mean the wilful and deliberate killing of oneself or another out of motives of compassion, the desire to save another from suffering, or to promote "the dignity"

15. See Kamisar, *supra* note 1, at 993-1005. Kamisar notes that the pool of candidates for euthanasia has not been restricted to "rational" incurable patients, but has been extended by some proponents to include the "insane" and otherwise "defective." *Id.* at 995. Dr. O. Ruth Russell, writing in the 1970's, advocated involuntary euthanasia for a wide range of impaired elderly and infant persons. O.R. RUSSELL, *FREEDOM TO DIE* 236-51 (rev. ed. 1976).

16. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). See Gelfand, *Euthanasia and the Terminally Ill*, 63 NEB. L. REV. 741 (1984).

17. Professor Gelfand is skeptical that a reliable line can be drawn between the withdrawal of "extraordinary" measures from terminally ill patients, and the practice of mercy-killing. Gelfand, *supra* note 16, at 774-76. While in agreement with much of Gelfand's thesis, the authors contend that there is a very real distinction between the legitimate withdrawal of non-beneficial or unduly burdensome medical treatment, based on the medical indications of a given case, and mercy-killing by passive means. This line, admittedly, is difficult to draw. However, it is a line that is often blurred by the proponents of euthanasia, such as Joseph Fletcher, whose cause stands to benefit from confusion on this issue. See, Horan, *Euthanasia and Brain Death: Ethical and Legal Considerations* 315 ANNALS N.Y. ACAD. SCI. 363, 370 (1978).

of the suffering person.¹⁸

Euthanasia is thus a form of homicide in which particular factors of intent and motive are present. These factors in no way exonerate the individual who has committed the homicide; nor does the fact that the homicide was committed by a negative rather than a positive act. These clarifications are important for several reasons. First is to maintain the traditional understanding of the law that motive does not excuse an act of euthanasia.¹⁹ Proponents of euthanasia have argued that the special factors of humanitarian motive and intent ought to remove acts of euthanasia from the jurisdiction of the criminal law.²⁰ The law has consistently rejected this point of view, and insists that a "mercy-killing" is no different from any other kind of homicide.²¹ In *State v. Ehlers*, the New Jersey court stated: "If the proved facts established that the defendant did the killing wilfully, that is, with intent to kill . . . and as a result of premeditation and deliberation, thereby implying preconsideration and determination, this is murder in the first degree, no matter what the defendant's motive may have been . . ." ²²

The second principal reason for maintaining these clarifications is to avoid the unprincipled and unjustified distinction between acts of "passive" and "active" euthanasia. The Declaration on Euthanasia issued by the Vatican in 1980 states: "By euthanasia is understood *an action or omission* which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used."²³ At present, we may assume that there is great resistance to direct forms of euthanasia among the health care professions. However, the practice of passive euthanasia appears easier to justify, largely because acts of passive euthanasia can, on the surface, closely resem-

18. The precise wording, derived from a variety of sources, is suggested by Rev. Robert Barry, *Moral theologian*: "Stay the mercy killer's hand," *Our Sunday Visitor*, Nov. 17, 1985, at 20.

19. Note, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME L. REV. 1202, 1203 (1973).

20. See Russell, *supra* note 15, at 232.

21. Horan, *supra* note 6, at 209.

22. 98 N.J.L. 236, 240 (1922).

23. DECLARATION ON EUTHANASIA (1980), reprinted in PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 300, 303 (1983) (hereinafter cited as REPORT OF THE PRESIDENT'S COMMISSION).

ble legitimate decisions to discontinue treatment or therapy.²⁴ Thus, it is critically important to emphasize that the

24. See *supra* notes 16-17. A recent policy "clarification" by a seven-member panel of the American Medical Association is perhaps the clearest evidence of medicine's willingness to accept the practice of euthanasia by omission, while attempting to maintain a stance against active or direct mercy-killing. "For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death." Statement of the Council on Ethical and Judicial Affairs, American Medical Association (March 15, 1986). The council further stated that where a terminally ill patient is incapable of making decisions on his own behalf, treatment can be withdrawn after consideration of the patient's prognosis, comfort, prior expressed wishes, and the attitudes of the family of the patient. These aspects of the AMA policy are in essence restatements of an earlier Judicial Council opinion, and do not on their face countenance the practice of euthanasia.

However, two critical "clarifications" by the Council clearly raise the prospect of euthanasia by omission under medical auspices. First is the extension of the category of patients to include situations where "death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis." Despite use of the term "coma," it is evident that this clarification will be interpreted to cover patients who are not technically afflicted with coma, but rather, are in a persistent vegetative state. See Malcolm, *A.M.A. Rule: Step Toward a Social Policy on Dying*, N.Y. Times, Mar. 17, 1986, at B-7, col. 1 (referring to patients such as Paul Brophy as in "coma", although medical testimony in their respective cases clearly indicated that "coma" is the incorrect diagnostic term.)

The second clarification is the Council's pronouncement that "life prolonging medical treatment includes *medication* and artificially or technologically supplied respiration, *nutrition or hydration*." Accordingly, the AMA policy would permit the removal of nutrition and hydration, a course which is certain in all cases to result in death, from patients who are permanently comatose or in a persistent vegetative state. Thus, the policy neatly fits the definition of euthanasia proposed by the authors, and supported by legal precedent and other competent authority. The impact of this policy upon the ongoing debate over the provision of food and water to terminally ill and profoundly incompetent patients (see *infra* notes 62-75 and accompanying text) remains to be seen. At least one commentator, however, has recognized the inherent conflict between the direction of policy as embodied in the AMA statement, and the policy of law towards handicapped persons, many of whom, it should be noted, require assistance in feeding.

Thus, the "food and water" issue must be seen for what it is: the entering wedge of an ethic which would permit intentional steps to end the lives of the disabled Once intentional steps to cause death — rather than passive measures which permit the condition or disease to take its natural course — have been approved, the inescapable conclusion is that it is the *existence* of the disabled person which constitutes the undesirable condition.

law can no more make an exception for homicide committed by "passive" means than it can make an exception for homicide committed for compassionate motives. The result in either case is the same: the creation of an exception to the homicide law based on subjective factors that will not submit to precise definition or limitation.²⁵

This is particularly so in the case of passive euthanasia, since the potential targets are those who are most dependent upon others for basic means of support. Legal doctrines which diminish the obligation to provide these means of support, even if they do not explicitly endorse euthanasia, lead to an erosion of the jurisprudential principles under which passive euthanasia is prohibited. Even if it were possible to permit these forms of passive euthanasia, while drawing a firm line against active euthanasia, a possibility we do not admit, the likely outcome would be widespread death by neglect. Under these conditions, it would be hypocritical to maintain a prohibition against active euthanasia.

The "remedy" for certain disabilities under the functional ethic is death. Food and water — the basic requirements of life itself — are redefined as medical "treatments" which can be withdrawn when the patient can no longer be made whole. Death, then, becomes the "final solution" for those whose disabilities make them — to borrow a phrase — "useless eaters."

Destro, *Quality-of-Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*. 2 J. HEALTH CARE POL'Y. & L. (Forthcoming, 1986).

25. Precisely, the homicide law that is left once an exception is created for the "hard" cases presented by the advocates of euthanasia will be a law that is riddled with exceptions for the terminally ill, the comatose, the vegetative, the infirm, and others requiring constant care. According to Professor Kamisar, the appropriate response to the often-poignant circumstances of mercy-killing may be "elasticity and flexibility" in determining the degree of criminal culpability and sentence. Kamisar, *supra* note 1, at 971-72. This is an appropriate course, Kamisar states, because in a matter as serious as homicide, "[t]he defendant is not always entitled to a sentimental acquittal." *Id.* at 971 (emphasis added).

Arthur Dyck notes that the merciful intentions of the proponents of euthanasia do not ameliorate the foreseeable consequences of an ethic that permits mercy-killing. "[T]he argument for beneficent euthanasia, unlike arguments for killing in self-defense, applies logically to a wide range of cases, and the reasons for keeping the range of cases narrow are not reasons on which people will easily agree." Dyck, *Beneficent Euthanasia*, in DEATH, DYING, AND EUTHANASIA (1977).

II. LEGISLATIVE DEVELOPMENTS

A. *Statutory Definition of Death*

Proposals to "define" death by standards other than the traditional cessation of respiratory and circulatory functions arose in response to the ability of medical science to artificially maintain those functions in persons who had irreversibly lost the ability to do so spontaneously.²⁶ The first statute of this type was enacted in Kansas in 1970.²⁷ At that time, there was potential that resolution of the brain death question would be swept into the controversy over euthanasia, by using the concept of "brain death" to expand the traditional concept of death to include those who are not dead, but profoundly disabled.²⁸ The intervention of the American Medical Association and the American Bar Association, along with other groups, prevented such an occurrence. A joint ABA-AMA committee produced the draft of what is now known as the Uniform Determination of Death Act (UDDA).²⁹ The UDDA provides a clear substitute for the jumble of "brain death" definitions that had been enacted by statute or court decision during the 1970's, and more importantly, prevents misuse of the brain death standard to facilitate euthanasia.

Under the UDDA, the question of brain death is confined to a matter of medical diagnosis. The UDDA permits death to be diagnosed under neurological criteria when those criteria establish that there has been total and permanent ces-

26. This question arose as early as 1957, when it was addressed to Pope Pius XII by a group of anesthesiologists. The Pope responded with an allocution, *The Prolongation of Life*, which has been widely quoted in legal and ethical circles for its teaching on the responsibility of the physician in the use of extraordinary means of treatment. The Pope also commented on the question of diagnosing death, responding to the doctors' question of whether it is proper to keep a body "alive" in the absence of brain function. "It remains for the doctor . . . to give a clear and precise definition of 'death' and the 'moment of death' of a patient who passes away in a state of unconsciousness." Pius XII, *The Prolongation of Life*, in THE POPE SPEAKS 393-98 (1958), quoted in Korein, *The Problem of Brain Death: Development and History*, 315 ANNALS N.Y. ACAD. SCI. 21, 28 (1978). In addition to Volume 315 of the Annals of the New York Academy, the report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research provides a good overview of the subject of brain death. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH, *DEFINING DEATH* (1981) [hereinafter cited as *DEFINING DEATH*].

27. 77 KAN. STAT. ANN. § 202 (Supp. 1979).

28. See *infra* notes 31-35.

29. *DEFINING DEATH*, *supra* note 26, at 72-73.

sation of all functions of the brain. "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."³⁰ Under this standard, a patient with partial brain function, even if it is limited to the so-called "vegetative" functions of the brain stem, cannot be declared dead. This is a significant advance over some earlier statutory approaches, which seem to leave open the possibility that such patients could be declared dead.³¹ In addition, it soundly rejects the proposal that brain death be equated with "cortical death."³² This formulation would permit a diagnosis of death when the higher functions of the brain had been irretrievably lost, on the theory that loss of these functions is tantamount to loss of personhood.³³ As noted by the President's Commission for the Study of Ethical Problems in Medicine,³⁴ the adoption of this definition "would depart radically from the traditional standards [T]he new standard would assign no significance to spontaneous breathing or heartbeat. Indeed, it would imply that the existing cardiopulmonary definition had been in error all along, even before the advent of respirators and other life-sustaining technology."³⁵ Rejection of "cortical death," therefore, pre-

30. *Id.*

31. None of the 25 statutes passed prior to the adoption of the UDDA specifically stated that "vegetative" patients could be declared dead. However, such a declaration remained a possibility under those statutes which did not specify that the loss of brain function must be total, and must include the brain stem as well as the higher brain functions. ARK. STAT. ANN. §§ 82-537 to -538 (Supp. 1981) ("A person is legally dead when the brain has irreversibly ceased to function"); GA. CODE ANN. § 88-1715.1 (Supp. 1980) ("A person may be pronounced dead if it is determined that the person has suffered an irreversible cessation of brain function."); HAWAII REV. STAT. § 327C-1(b) (Supp. 1980) ("when irreversible cessation of brain function first occurred"); KAN. STAT. ANN. § 77-202 (Supp. 1979) ("the absence of spontaneous brain function").

32. DEFINING DEATH, *supra* note 26, at 75.

33. Among the proponents of this position were philosophers Tristram Englehardt, Jr. and Robert M. Veatch. See DEFINING DEATH, *supra* note 26, at 38-39; Veatch, *The Definition of Death: Ethical, Philosophical and Policy Confusion*, 315 ANNALS N.Y. ACAD. SCI. 307 (1978). But see D. WALTON, ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS 69-80 (1983) (discussion and critique of Veatch viewpoint that diagnosis of death is permissible in patients with persistent vegetative state).

34. DEFINING DEATH, *supra* note 26, at 40-41.

35. Horan, *supra* note 17, at 367.

vents an obvious form of euthanasia: the redefinition of the living as dead.

The UDDA thus thwarts an important semantical shift in the euthanasia debate: the creation of an ill-defined category of "brain dead" persons as candidates for euthanasia. The UDDA does not expand the category of "dead" patients beyond that existing at common law. It also represents a setback to the opportunism which has seized upon the dilemmas created by advancing medical technology to weaken the legal prohibitions against euthanasia. This opportunism, however, has been very successful in several other legislative proposals, most notably, the concept of the "living will." Our attention now turns in that direction.

B. "Living Will" Legislation

1985 was a decisive year for advocates of legislation recognizing the validity of "living wills:" documents which allow a patient to direct that certain measures not be used to sustain his life in the event that he becomes terminally ill and is incapable of participating in treatment decisions. At the outset of 1985, less than half of the states had enacted such laws. By the end of 1985, living will laws were on the books in thirty-six states.³⁶ Also during 1985, the National Conference

36. ALA. CODE §§ 22-8A-1 to -10 (1980); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (Supp. 1985); ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985); COLO. REV. STAT. §§ 15-18-101 to -113, 12-36-117(1)(s) (Supp. 1985); Living Wills, P.A. 85-606, 1985 Conn. Legis. Serv. No. 7, at 541 (West); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. § 6-2421 to -2430 (Supp. 1984); FLA. STAT. ANN. §765.01-.15 (West Supp. 1985); GA. CODE ANN. §§ 88-4101 to -4112 (Supp. 1985); IDAHO CODE §§ 39-4501 to -4508 (1985); ILL. ANN. STAT. ch. 110 ½, §§ 701-710 (Smith-Hurd Supp. 1985); IND. CODE ANN. §§ 16-8-11-1 to -22 (West Supp. 1985); Life-Sustaining Procedures Act, Senate File 25, 1985 Iowa Legis. Serv. No. 1 at 2 (West); KAN. STAT. ANN. §§ 65-28-101 to -109 (1980); LA. REV. STAT. ANN. §§ 1299.58.1-.10 (West Supp. 1985); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1985); MD. HEALTH GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1985); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1985); Death Prolonging Procedures Act, S.B. No. 51, 1985 Mo. Legis. Serv. No. 4, at 15 (Vernon); MONT. CODE ANN. §§ 50-9-101 to -111 (Supp. 1985); NEV. REV. STAT. §§ 449.540-.690 (1983); N.H. REV. STAT. ANN. §§ 137-H:1 to H:16 (Supp. 1985); N.M. STAT. ANN. §§ 24-7-2 to -10 (Supp. 1984); N.C. GEN. STAT. §§ 90-320 to -323 (1981); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (Supp. 1985); OR. REV. STAT. §§ 97.050-.090 (1983); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1985); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1985); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1985); VT. STAT. ANN. tit. 18 §§ 5251-5262 (Supp. 1985); VA. CODE §§ 54-325.8:1 to

of Commissioners on Uniform State Laws approved the Uniform Rights of the Terminally Ill Act (URTIA), which is intended to serve as a model to replace existing living will statutes. As a result, living will laws can no longer be viewed as a temporary legislative experiment in the field of death and dying. Whether or not the Uniform Act is enacted to replace existing laws, the living will is now a fixture on the legislative scene in most of our states, and is an important component in discussing the legal status of euthanasia.³⁷

In keeping with the central theme of this article, our principal question is whether existing living will laws and the proposed Uniform Act weaken the general legal prohibition of euthanasia. Disclaimers to the contrary appear in the text of virtually all living will laws, including the Uniform Act, and in the policy statements of the advocates of the living will. Yet, there is abundant evidence that, notwithstanding these disclaimers, most living will laws create a legal climate favorable to the legalization of euthanasia, and that some include legal mechanisms that would permit the practice of euthanasia. The following sections of this part will examine how living will laws impact upon some of the major issues in the euthanasia debate: the patient's right of self-determination, the standard of medical care towards the terminally ill, and the practice of passive euthanasia. A final section will explore possible alternatives to existing living will legislation.

1. Living Wills and the Right to Self-Determination

The underlying issues in living will legislation are the obligations of care-givers to treat incompetent, terminally ill patients, and the ability of persons who might eventually become incapable of making treatment decisions to state, in advance, how they prefer to be treated. Some would say that only the second of these issues is addressed by living will laws,

:12 (Supp. 1985); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (Supp. 1985); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1985); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1985). As this article was in final preparation, South Carolina enacted a living will proposal. For an analysis of all enacted statutes in this area, as well as case law, see SOCIETY FOR THE RIGHT TO DIE, *THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT* (1985).

37. Contrasting views of the merits of living will legislation, and its impact on the euthanasia debate, may be found in Gelfand, *supra* note 16, at 750-53; and Martyn & Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779 (1984).

and that these laws have no bearing on the general obligation to provide medical treatment that is beneficial. This argument has a veneer of credibility. On their face, living will laws appear to be simple statutory recognition of common law rights of self-determination regarding medical treatment. The patient is given the right to state his treatment preferences in the event that he loses capacity to decide for himself.³⁸

In other respects, however, the legal doctrines established by living will legislation are quite contrary to the normal practice of medical informed consent. The living will is unidirectional in preserving the right to consent to medical treatment beyond the point of incompetency. With the exception of a handful of statutes,³⁹ living will laws do not permit patients to request that treatment be provided; they only permit patients to refuse treatment. The drafting committee of the Uniform Law Commissioners considered and rejected a proposal that the URTIA give patients the explicit right to a treatment declaration requesting, as well as declining, treat-

38. Such legislation ostensibly provides an opportunity for a written and enforceable expression of patient choice should the person become incompetent during terminal illness. To justify living will legislation upon this ground alone, however, presumes that the physician would be liable for failure to extend heroic treatment to the patient in the absence of a specific refusal by the patient. But short of abandonment, the physician is under no obligation to initiate or continue heroic or useless treatment. Indeed, physicians customarily with familial consent discontinue or fail to initiate such treatment without violating the ethical norms of the community of their profession and there is as yet no reported case, civil or criminal, in which liability has been attached for discontinuance of treatment for the terminally ill.

Horan & Marzen, *Death With Dignity and the Living Will: A Commentary on Legislative Development*, 5 J. LEGIS. 81 (1978).

39. ARK. STAT. ANN. §§ 82-3801 to -3802 (1977) ("Alternatively, every person shall have the right to request that such extraordinary means be utilized to prolong life to the extent possible."); IND. CODE ANN. § 16-8-11-10 (West Supp. 1985) (patient may request that all procedures to "extend life" be employed, and physician is bound to honor such a request).

Whatever the merits of this provision of the Arkansas law, other aspects make this a highly flawed approach that poses a great risk of legalized euthanasia. For example, there is no provision which limits application of a decision to remove treatment to cases of terminal illness. In addition, a binding treatment directive may be made on behalf of an incompetent person. The overall lack of precision in the statute poses a great risk of abuse, even to the extent of permitting involuntary passive euthanasia. See Horan & Grant, *Prolonging Life and Withdrawing Treatment: Legal Issues*, 50 LINACRE Q. 153, 166 (1983).

ment.⁴⁰ Thus, although the URTIA professes to err on the side of life,⁴¹ it follows the consistent pattern of other living will laws in not permitting patients to use their living will to personally opt for the continuation of life.

It is questionable, therefore, whether the intent of the living will is to preserve the patient's right of self-determination, or whether the intent is to make it easier for physicians, families and institutions to cease efforts at prolonging life. Further basis for skepticism is provided by the suggested directives that are present in most versions of these statutes. Although these forms vary, that contained in the URTIA is representative:

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and if I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the [name of statute] to withhold or withdraw treatment that only prolongs the dying process and is not necessary to my comfort or to alleviate pain.⁴²

When executed at a time and place remote from the circumstances of a person's eventual terminal illness, a document such as this is inadequate, by itself, to guide treatment decisions. However, the URTIA invests in this document a legal authority that is virtually absolute. The directive can: require a physician to terminate his or her prescribed mode

40. The proposal was offered at a public session of the drafting committee that authored the Uniform Act, held in Hartford, Connecticut, in October 1984, at which one of the authors was in attendance. The reasons given for rejecting this proposal were that very few existing statutes include provisions allowing patients to request treatment, and that permitting patients to do so would raise the possibility that patients could, through a treatment directive, demand treatment that may be inappropriate, experimental or excessively expensive. The latter risk, however, would be more attributable to the mandatory and binding nature of the treatment directive than to the provision permitting patients to request treatment. If the statute gave physicians the discretion to consider whether the course of treatment requested would be appropriate under the totality of circumstances, there would be no question of forcing physicians to provide treatment that was contrary to medical indications or their own professional judgment.

41. UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1 comment (1985) [hereinafter cited as URTIA]. References in this article to the URTIA are made to the typescript copy of the Act, which is available from National Conference of Commissioners on Uniform State Laws, 645 North Michigan Ave. Suite 510, Chicago, Illinois 60611.

42. *Id.* § 2.

of treatment; force an institution to transfer a patient if the institution is unwilling to comply with the directive; provide a basis for misdemeanor criminal charges against a physician who wilfully fails to note a diagnosis of terminal illness for a patient who has signed a directive, or against a physician or health care provider which fails to comply with a directive and also fails to transfer the patient. The only limitation on this authority is the URTIA stipulation that it does not require "any action contrary to reasonable medical standards."⁴³

Each of these obligations and potential penalties arise at any time a patient reaches the qualifying conditions of terminal illness and incompetency to make treatment decisions. This is true whether the patient be relatively young or old, single or married, childless or a great-grandfather. Moreover, these obligations arise regardless of the nature of the terminal illness or the life-prolonging treatment involved. A healthy person may consider any number of these potential variables relating to a terminal illness, and nevertheless decide to execute a directive. However, no one can even theoretically contemplate all of the factors that will be operative when he becomes terminally ill. Apart from the limits of human perception and imagination, there is the fact that advances and changes in medical science and options for care may render today's contemplation of terminal illness totally irrelevant.⁴⁴ The vision of prolonged death in an intensive care environment may, for example, be rendered obsolete by advances in hospice care and pain control. The experience of the hospice movement, in fact, offers conclusive evidence that the attitudes of dying patients towards medical treatment can change dramatically depending upon the setting of that

43. Section 9 of the URTIA provides that the wilful failure to comply with the terms of a living will is a misdemeanor, and section 10(f) contains the "medical standards" exceptions.

44. The President's Commission for the Study of Ethical Problems in Medicine has criticized the binding nature of living will directives, stating that they do not "provide self-determination in the sense of active moral agency by the patient on his or her own behalf." REPORT OF THE PRESIDENT'S COMMISSION, *supra* note 23, at 137.

Hence, a decision not to follow an advance directive may sometimes be justified even when it would not be acceptable to disregard a competent patient's contemporaneous choice. Such a decision would most often rest on a finding that the patient did not adequately envision and consider the particular situation within which the actual medical decision must be made.

Id.

treatment and the quality of support for the individual patient.⁴⁵ Moreover, those who execute living wills while healthy may change their minds at a later time. If they have neglected to revoke their living will, this now-antiquated directive would retain the force of law. Care providers who would ignore the directive under such circumstances risk significant liability.

The URTIA, like other living will proposals, fails to adequately protect the "rights" of the terminally ill, even the basic right of self-determination regarding medical treatment. The deficiencies of the living will were noted by the New Jersey Supreme Court in *In re Conroy*, where the court held that persons have a common-law right to make advance treatment directives which will govern in the event that they are terminally ill, incompetent, and confined to a nursing home. The court held that where such a directive, given in advance, states a general desire not to have life "prolonged" by "artificial" measures, it does not constitute clear and convincing evidence that will permit the withdrawal of life-sustaining treatment.⁴⁶ *Conroy* provides a useful point of departure for future legislative initiatives on this subject matter. In order to be legally binding, evidence of a patient's decisions regarding treatment should be far more specific, both as to the nature of the treatment that may be withdrawn, and as to the level of physical impairment that a patient would consider accept-

45. An extensive literature attests to the success of the hospice philosophy in meeting the needs of terminally ill patients. See R. BUCKINGHAM, *THE COMPLETE HOSPICE GUIDE* (1983); E. KÜBLER-ROSS, *QUESTIONS AND ANSWERS ON DEATH AND DYING* (1974); E. KÜBLER-ROSS, *ON DEATH AND DYING* (1969); R. LAMERTON, *CARE OF THE DYING* (1973); A. MUNLEY, *THE HOSPICE ALTERNATIVE: A NEW CONTEXT FOR DEATH AND DYING* (1983). It is significant that those involved in hospice care tend to be vigorously opposed to euthanasia, while at the same time opposing the use of invasive, technological procedures upon patients in the final stage of terminal illness. "As far as the hospice is concerned, legalization of euthanasia would be nothing more than a cheap, expedient solution to be problem of terminal care at the expense of the patient's best welfare." A. MUNLEY, *supra*, at 274-75. Precisely because of its proven ability to promote the patient's welfare, while resolving the societal problem of inadequate care for the terminally ill, "the hospice movement can be a powerful force for undercutting a movement for active euthanasia." *Id.* at 275. Despite the rather volatile environment of the American health care industry, the hospice movement has successfully adapted to the economic pressures without compromising its original ideals. Tehan, *Has Success Spoiled Hospice?*, *HASTINGS CENTER REP.*, Oct. 1985, at 10.

46. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1231 n.7 (1985).

able.⁴⁷ In their current form, living will laws provide legal protection for physicians and others to remove life-prolonging treatments, but they provide scant protection for the right to make a genuinely informed decision regarding treatment.

2. Living Wills and Standards of Patient Care

Current forms of the living will clearly skew the decision of patients in the direction of refusing medical treatment. Advocates of the living will state that this is necessary to protect the patient's "right to die" without unwanted medical intervention. Enactment of the living will, therefore, would appear to establish a public policy in favor of medical decisions that honor the "right to die." It is questionable, in the current environment of health care, whether this public policy will be a benefit to society.

The traditional ethics of medical practice, in which a relationship of physician-patient trust was premised on the assumption that the physician would always advance the patient's interests first, have been shaken. The drive towards cost containment and the expansion of the for-profit sector in the health care market already ensures that interests other than those of the patient are taken into account in making many treatment decisions.⁴⁸ Perhaps we have not yet reached a point where these ancillary interests are decisive; we have clearly reached a point where they are influential. Dr. Mark Siegler and Alan Weisbard have acutely observed the intersection between these economic factors and the "right to die" philosophy that lies at the heart of living will legislation.

[F]or an increasing number of patients, the benefits of continued life are perceived as insufficient to justify the burden and cost of care; . . . death is the desired outcome, and . . . the role of the physician is to participate in bringing this about. . . . [C]ost containment strategies may impose significant financial penalties on those who provide prolonged care for the impaired elderly. In the current envi-

47. See discussion of standards created by *Conroy*, *infra* notes 131-40 and accompanying text.

48. For an overview of the impact of cost-containment on the traditional ethics of medical practice, see Cassel, *Deciding to Forego Life-Sustaining Treatment: Implications for Policy in 1985*, 6 *CARDOZO L. REV.* 287 (1985); Siegler & Weisbard, *Against the Emerging Stream—Should Fluids and Nutritional Support Be Discontinued?* 145 *ARCHIVES INTERNAL MED.* 129 (1985).

ronment, it may well prove convenient—and all too easy—to move from recognition of an individual's "right to die" (to us, an unfortunate phrasing in the first place) to a climate enforcing a "duty to die."⁴⁹

Other researchers have documented that the fears of Siegler and Weisbard are not idle. Dr. Christine Cassell reports that some policy planners have suggested that Medicare patients be provided living wills upon admission to the hospital—not for the purpose of securing a course of treatment that is appropriate from the patient's standpoint, but in the interests of cost containment.⁵⁰ Paul Starr, in *The Social Transformation of American Medicine*, provides evidence that pressure upon individual physicians to generate income will lead to discrimination in care based on the level of private insurance, if any, carried by the patient.⁵¹ Cassell observes how the convergence of such forces alters the ethics of medical practice:

As long as a decision about life-sustaining therapy is made in the moral intimacy of the physician-patient relationship, the physician wanted to engage in the struggle of conscience privately, weighing the values of patient, and family, and her own. But now she is being asked to let patients die because they cost too much, or to obfuscate, because we face the problem of allocation of scarce medical resources. . . . [Physicians] are expected to be the new gatekeepers of society's wealth.

. . . . Bolstered by the rhetoric of compassion, common sense, and death with dignity, we will see a new practice, which can ominously be called "kill the dying."⁵²

In such an atmosphere, living will legislation is likely to cause further erosion in the medical profession's ethos of preserving life, and in the barriers that have heretofore prevented serious public consideration of legalized mercy-killing. This erosion starts with acceptance of the subtle but powerful assumption that the alleged over-treatment of terminally ill and profoundly impaired patients is inimical to the interests of such patients, as well as to the interests of the medical pro-

49. Siegler & Weisbard, *supra* note 48, at 131.

50. Cassel, *supra* note 48, at 293.

51. P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 436-47 (1982).

52. Cassel, *supra* note 48, at 289, 293-94.

fession and of society at large. When the "over-treatment" thesis is more closely analyzed, it is apparent that even relatively simple measures, such as the provision of food and fluids, are part of the alleged problem. This is because the "over-treatment" thesis does not focus solely on the quality of, or medical indications for, the treatment in question. Rather, the thesis is closely tied to the assumption that the patient's "quality of life" is also a determinative factor in treatment decisions. With acceptance of the "over-treatment" thesis, death of the patient emerges as a favored outcome in a significant number of cases where quality of life is perceived to be low, and the major ethical problem is what boundaries, if any, to place in the way of hastening death. Living will legislation, because it is founded on the over-treatment thesis, thus represents a more important shift in public policy towards medical practice than is commonly recognized. As seen by the recent experience of California, where legislation to amend that State's Natural Death Act (living will) would permit the administration of direct means of killing to certain terminally ill patients, the alteration of public policy by passage of the living will will make future proposals for more direct forms of euthanasia more palatable.⁵³

Thus, by altering their legislative agenda away from the volatile question of direct euthanasia to the more subtle agenda of the living will, groups such as the Society for the Right to Die and Concern for Dying have achieved a great deal in lowering legal and social constraints on euthanasia.⁵⁴

For the first three decades of its organized existence, the euthanasia movement met with little success in the political or legal arenas. The legislative agenda of permitting active euthanasia of the terminally ill was stalled in part because the difficulties of illness were a personal and medical problem, most often confronted in a family context.⁵⁵ Today, these problems are social and economic, and although they are still confronted by doctors, nurses, hospitals and families, the solutions are purported to have a social and economic impact. In recent years, social issues, such as euthanasia, have often been given to the health care professions to solve by medical means. In this case, the social issue of care for the aging and dying has become medicalized, and the medical issue of the

53. See *supra* note 4 and accompanying text.

54. See *supra* note 4 for a discussion of "right to die" organizations in the United States and abroad.

55. REPORT OF THE PRESIDENT'S COMMISSION, *supra* note 23, at 16.

proper scope of treatment has become socialized.

The euthanasia movement has successfully seized upon the opportunity presented by this climate to press for acceptance of the living will. The movement's success is not only political, for it has also fostered greater acceptance in medical practice of the attitude towards death as a desired outcome. Such legislation also provides a measure of comfort to physicians who are understandably concerned about growing legal liabilities. On the personal side, living will laws provide an outlet for the human yearning for an easy and comfortable death in lieu of a prolonged dying.

While it is easy to support the goal of reduced human suffering, we should not be deterred from a rigorous examination of the public policy proposals that are advanced in the cause of euthanasia. The goal of preventing prolonged, painful death is difficult to oppose, but the translation of this goal into specific legislation creates the risk of compromising other interests that are even more fundamental to our societal notions of justice. As Professor Kamisar has noted, the price of maintaining the rights of all citizens against the ethic of mercy-killing may include the temporary continuation of life for certain individuals who would rather die.⁵⁶ This is a difficult proposition to defend in contemporary society, but as Kamisar noted, virtually all of our most cherished liberties—including freedom of the press and freedom of religion—require the tolerance of conditions that are perceived to be obnoxious. The process of dying can be the most difficult of human conditions to tolerate—not only for the dying person, but also for those who are responsible for that person's care. The danger, therefore, is that this second category of persons, representing society as a whole, will cease to tolerate the difficulties of this care, and turn to the practice of mercy-killing as a solution. Over-eager acceptance of public policies which favor the death of patients will enlarge this danger, because the magnitude and breadth of human suffering will continually expand the population of those for whom death is seen as a desired outcome.

3. Living Wills and the Practice of Passive Euthanasia

Most living will statutes disclaim any intent to legalize or otherwise endorse the practice of euthanasia.⁵⁷ The dis-

56. Kamisar, *supra* note 1, at 1041-42.

57. Approximately 27 of the existing living will statutes contain such

claimer in the URTIA is representative: "This Act does not condone, authorize or approve mercy-killing or euthanasia."⁵⁸ Significantly, the model living will law drafted in 1978 at a conference sponsored by the Society for the Right to Die contains no such disclaimer.⁵⁹ None of the enacted statutes define what is meant by "euthanasia" or "mercy-killing," and none create any new prohibitions or penalties upon the practice of euthanasia. Therefore, the euthanasia disclaimers, which are evidently included in living will legislation to alleviate political controversy, do little or nothing to stem the erosion in legal prohibitions against euthanasia.

Indeed, certain mechanisms of the living will statutes appear on their face to undermine these prohibitions. The first of these mechanisms is the immunity granted to physicians for decisions to withdraw treatment from a "qualified," usually meaning terminally ill,⁶⁰ patient who has executed a living will. The purpose of the immunity provision is understandable. Absent immunity, prudent physicians may be reluctant to rely upon the living will as adequate proof of the patient's consent to withdrawal of the particular treatment in question. In addition, the public policy advanced by such legislation is to encourage acceptance of the "right to die" by physicians and the public.⁶¹ If physicians are immune to legal penalties for activity which protects this "right," this policy will be served.

It is questionable, however, whether accomplishment of these purposes outweighs the significant negative consequences of granting blanket immunity to decisions made under a living will. The threat of civil or criminal liability for improper withdrawals of medical treatment is an appropriate reinforcement of the standards of medical ethics, particularly concerning vulnerable patients who are no longer able to defend their own interests.⁶² Given the open-ended nature of the treatment directive in most living will legislation, physicians should be encouraged to proceed cautiously when a living will is to be given effect. Although the statute and the form declarations lump together all "life-prolonging proce-

clauses. Those that do not include Arkansas, Colorado, Connecticut, Delaware, Idaho, New Mexico, North Carolina, and Vermont. For citations of statutes, see *supra* note 36.

58. URTIA, *supra* note 41, § 10(g).

59. REPORT OF THE PRESIDENT'S COMMISSION, *supra* note 23, at 313-17.

60. See, e.g., URTIA, *supra* note 41, § 1(7).

61. See Gelfand, *supra* note 16, at 750-51.

62. See Kamisar, *supra* note 1, at 971-77.

dures" as if they were one category of treatment,⁶³ the physician should be permitted and even obligated to exercise his professional judgment and expertise to examine each form of treatment being provided to a patient, and to decide whether withdrawal of that treatment is ethically and legally appropriate.⁶⁴ It is reasonable to assume that in practice, most physicians will continue to work in this fashion, and thus prevent abuse of the living will. However, the immunity granted by these statutes leaves open another possibility: that treatment will be summarily withdrawn from terminally ill, incompetent patients at an arbitrary point. An alternative to blanket immunity should be devised so that the practice of honoring a patient's request not to have life needlessly prolonged in the final stages of terminal illness does not become a pretext for abandonment of such patients.

A second aspect of living will legislation which may permit the practice of euthanasia is the failure of such legislation to adequately define the forms of treatment that may be withdrawn from patients, and the circumstances under which withdrawal can take place. The type of treatment that can be withdrawn under the URTIA, called "life-sustaining treatment," is defined as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying."⁶⁵ A "qualified patient" is a patient over 18 "who has executed a declaration and has been determined by the attending physician to be in a terminal condition."⁶⁶ A "terminal condition" is an incurable or irreversible condition that, "without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time."⁶⁷ Taken together, these terms define the circumstances under which a withdrawal of treatment that may result in death can be made under the URTIA.

The definitions are purposefully broad, and thus leave significant ambiguity, for example, on the question of what specific types of treatment may be withdrawn. According to

63. There is a trend in recent enactments to differentiate between the provision of nutrition and hydration, and medicines required for pain control on the one hand, and all remaining forms of life-sustaining therapy on the other. See *infra* note 69.

64. See REPORT OF THE PRESIDENT'S COMMISSION, *supra* note 23, at 137.

65. URTIA, *supra* note 41, § 1(4).

66. *Id.* § 1(7).

67. *Id.* § 1(9).

the comments of the committee that drafted the URTIA, treatments such as renal dialysis and insulin therapy are not included in the category of treatments that can be withdrawn. The committee supported this finding by the curious and medically inaccurate statement that renal failure and diabetes, because they can be effectively managed, are not "irreversible" conditions.⁶⁸

The committee failed to extend this logic, however, to the provision of nutrition and hydration. The need for mechanical assistance in providing nutrition and hydration can arise from many sources, just as the need for dialysis or insulin therapy. In all these cases, however, there is an underlying, vital need that is being met. Neither the text of the URTIA, nor the comments of its drafters, explain the different treatment which the URTIA gives to dialysis and insulin on the one hand, and nutrition and hydration on the other. Eschewing the approach of the many states which have specifically excluded nutrition in the category of life-sustaining treatment that can be withdrawn pursuant to a living will,⁶⁹ the URTIA sides with those statutes which contain no such exclusion and thus, by implication, permit the withdrawal of these measures under their living will.⁷⁰ Since provision of

68. *Id.* § 1 comment.

69. The following states expressly provide that nutrition and hydration are excluded from the category of life-sustaining treatments that may be withdrawn from a patient: Arizona, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Maryland, Missouri, Montana, Oklahoma, Tennessee, Washington, Wisconsin and Wyoming. In Montana, nutrition and hydration is excluded where the provision of nutrition and hydration is required for patient comfort. MONT. CODE ANN. § 50-9-202(2) (Supp. 1985). Thus, the exclusion might not apply where a patient is "beyond comfort," i.e., in a persistent coma. In Tennessee, there is no definition of "life-sustaining procedures," but the definition of "medical care" specifically includes "artificial or forced feeding." TENN. CODE ANN. § 32-11-103(5) (Supp. 1985). However, the act also states that "in no case shall [medical care] be interpreted to allow the withholding of simple nourishment or fluids so as to condone death by starvation or dehydration." *Id.* It is significant that sixteen of the twenty living will laws passed in 1984 and 1985 contain some distinction between nutrition and hydration, and medical treatment.

70. The URTIA's specific language on this point is as follows: "This [Act] does not affect the responsibility of the attending physician or other health-care provider to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain." URTIA, *supra* note 41, § 6(b). The comments to this provision indicate that the Commissioners did not understand the full reasons for excluding the provision of nutrition and hydration from the category of life-sustaining procedures subject to advance treatment directives.

nutrition by naso-gastric tube, gastrostomy or jujenostomy

If nutrition and hydration are not necessary for comfort care or the alleviation of pain, they may be withdrawn. This approach was deemed preferable to the approach in a few existing statutes, which treat nutrition and hydration as comfort care in all cases, regardless of circumstances, and exclude comfort from the life-sustaining treatment definition.

Id. § 6 comment. The Commissioner's misunderstanding of this issue results in part from a misconstruing of those statutes which exclude nutrition and hydration. *See supra* note 69. These statutes do not define nutrition and hydration as an aspect of comfort care; rather, they exclude *both* nutrition/hydration *and* comfort care from the category of treatments that may be withdrawn under the Act. The provision in the Life Prolonging Procedures Act of Florida is an example: "'Life prolonging procedure'" shall not include the provision of sustenance or the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or alleviate pain." FLA. STAT. § 765.03(3) (1984). Careful reading of this provision reveals that the modifier "deemed necessary to provide comfort care or alleviate pain" does not apply to the first two antecedents (sustenance and medication), but rather, to the last antecedent, "the performance of any medical procedure." The doctrine of statutory construction known as *reddendo singula singulis* holds that each phrase in a statute is to be applied to its appropriate object. BLACK'S LAW DICTIONARY 1148 (5th ed. 1979); 2A N. SINGER, STATUTES AND STATUTORY CONSTRUCTION § 47.26 (4th ed. 1984). In this case, the final clause of the provision is clearly intended to sweep in a broad category of treatments that may be requisite for patient comfort. However, if the legislature intended to exclude nutrition and hydration only to the extent that they provide comfort care, the prior "sustenance" clause would be redundant, for nutrition and hydration in such cases would be included as "any medical procedure deemed necessary to provide comfort care or alleviate pain."

The existing statutes referred to by the Commissioners, therefore, do not equate nutrition with comfort care, but rather, consider the provision of nutrition and hydration an element of basic care that ought to be provided notwithstanding the dictates of an advance treatment directive. The rationale for this distinction was expressed by Judge David Kopelman of the Massachusetts Probate and Family Court in Norfolk County, where he ruled that a gastrostomy feeding tube could not be removed from a 45-year-old man in a persistent vegetative state. *Brophy v. New England Sinai Hosp. Inc.*, No. 85E0009-G1 (Mass. Probate Ct., Norfolk, Oct. 21, 1985) *rev'd in relevant part*, No. 4152 (Mass. Sup. Jud. Ct. Sept. 11, 1986). "It is ethically inappropriate to cause the preventable death of Brophy by the deliberate denial of food and water, which can be provided to him in a noninvasive, nonintrusive manner which causes no pain and suffering, irrespective of the substituted judgment of the patient." *Slip. op.* at 23. Judge Kopelman contrasted the feeding tube to other forms of life-sustaining therapy, such as mechanical respirators, cardio-pulmonary resuscitation, and aggressive antibiotic therapy, and found that the continuation of feeding is far less invasive, intrusive and risky than any of these measures. *Id.* This distinction was rejected on appeal by the Massachusetts Supreme Judicial Court, which held in a 4-3 ruling that the patient's substituted judgment could be exercised by his family to withdraw the gastrostomy tube.

"reverses" the life-threatening inability to ingest food just as certainly as dialysis "reverses" life-threatening renal blockage, the statute's resolution of this issue is unsatisfactory. Moreover, the URTIA's reliance on existing statutes which contain no exclusion may be misplaced, since the medico-legal controversy over withdrawal of nutrition and hydration did not arise until after many of these statutes were enacted.⁷¹

Compounding the error is the statute's failure to perceive the special significance of nutrition and hydration as a "life-prolonging" measure. The difference between those statutes which omit nutrition and hydration from the operation of living wills and those statutes which do not is a very serious disagreement on policy. A substantial body of legal and ethical opinion considers the routine withdrawal of these elements to be euthanasia; other authorities, while not going this far, believe that withdrawal of food and water is a more serious matter than other decisions to terminate treatment.⁷² The URTIA professes to defer to medical decision-making opinion in this matter, but current opinion appears to be greatly divided on this question.⁷³ Since the questions of when withdrawal of nourishment and hydration is appropriate, and when such withdrawal constitutes euthanasia, are very open, the URTIA's decision to treat nutrition and hydration as a form of treatment that can ordinarily be withdrawn pursuant to a living will is difficult to reconcile with

71. The subject of nutrition and hydration has received a great deal of attention in journals of medical ethics and other forums only within the past five years. See, e.g., Lynn & Childress, *Must Patients Always be Given Food and Water?* HASTINGS CENTER REP., Oct. 1983, at 17; Micetich, *Are Intravenous Fluids Morally Required for a Dying Patient?*, 143 ARCHIVES INTERNAL MED. 975 (1983). But see Siegler & Weisbard, *supra* note 48. Not coincidentally, provisions which exclude nutrition and hydration from the definition of life-sustaining treatment appear predominantly in statutes that have been passed since 1983. Living Wills, P.A. 85-606, 1985 Conn. Legis. Serv. No. 7, at 541 (West); FLA. STAT. ANN. § 765.03(3) (Supp. 1985); GA. CODE ANN. § 88-4102(5) (Supp. 1985); ILL. ANN. STAT. ch. 110 ½, § 702 (C) (Smith-Hurd Supp. 1985); IND. CODE ANN. § 16-8-11-4 (West Supp. 1985); Life-Sustaining Procedures Act, 1985 Iowa Legis. Serv. No. 1, at 2 (West); ME. REV. STAT. ANN. tit. 22, § 2921.4 (Supp. 1985); Death Prolonging Procedures Act, S.B. No. 51, 1985 Mo. Legis. Serv. No. 4, at 15 (Vernon); WIS. STAT. ANN. § 154.01(5) (Supp. 1985).

72. See Horan & Grant, *The Legal Aspects of Withdrawing Nourishment*, 5 J. LEGAL MED. 595, 622-631 (1984), and discussion of *Brophy* case in note 70, *supra*.

73. See *supra* note 71. See also Note, *I.V. Withdrawal: The Severance of Medicine's or Society's Umbilical Cord?*, 63 NEB. L. REV. 941 (1984).

the URTIA's professed intention "to err on the side of preserving life."⁷⁴

In addition to dangerous ambiguity on the question of the types of treatment that may be withdrawn from a patient, the URTIA is plagued by its definition of "qualified patients" from whom treatment can be withdrawn. Under the URTIA, physician discretion determines whether a particular treatment serves solely "to prolong the dying process." The scope of the "dying process," however, is a highly subjective determination. In the case of certain chronic ailments, such as Alzheimer's disease, the difficulty of caring for patients may exert subtle pressure to enlarge the temporal scope of the "dying process."⁷⁵ Several statutes avert this danger by providing that treatment can be withdrawn only if the patient will die, regardless of whether the treatment is administered or not.⁷⁶ Thus, the only form of treatment that must be withdrawn under these living will statutes is truly futile treatment; treatment that is postponing a death that is both certain and inevitable.

Critics of this cautious approach to death legislation maintain that such provisions unduly restrict application of the living will.⁷⁷ The alternative they propose, however, raises other dangers. Under the URTIA, for example, the only medical requisite for operation of a living will is the presence of an irreversible or incurable life-threatening condition.⁷⁸ Any medical intervention which prolongs the life of a patient in such a situation may be withdrawn. The URTIA has thus confused two situations with consequences that are potentially quite different: the treatment of patients in the final stage of terminal illness, and the care of patients who are

74. URTIA, *supra* note 41, § 1 comment.

75. Evidence of this direction is provided in guidelines developed at a conference of physicians sponsored by the Society for the Right to Die. Wanzer & Adelstein, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955 (1984). An associate clinical professor of medicine at the University of Southern California has suggested the formulation of an "Alzheimer's Amendment" to existing living will laws to provide that when a patient with Alzheimer's disease reaches the point of dementia that spoon feeding becomes necessary, "it could be requested and written that no type of feeding be given." Marmorstein, *Could the New Jersey Decision Apply to Alzheimer's?*, Medical Tribune, March 27, 1985, at 38.

76. See, e.g., CAL. HEALTH & SAFETY CODE § 7187(f) (West Supp. 1985); WIS. STAT. ANN. § 154.01(8) (West Supp. 1985).

77. URTIA, *supra* note 41, § 1 comment.

78. *Id.* § 1(7).

greatly impaired, but nevertheless, could not be considered to be dying. Karen Quinlan might serve as an example of such a case. The withdrawal of life-sustaining treatment from patients in this second category involves legal and ethical considerations that are quite different from a decision to forego futile life-sustaining treatment in a truly terminal case.⁷⁹ A decision to forego treatment when life can be prolonged for an indefinite period of time is not necessarily based on a judgment that further treatment is futile or overly burdensome, but may be based on a judgment that the life in question is no longer worth preserving. As at least two courts have recognized, such a decision may be tantamount to euthanasia.⁸⁰ To the extent that the URTIA will encourage such decisions to be made, it will have lowered a significant barrier to the practice of euthanasia.

It is evident that the benefits that flow from living will legislation do not outweigh these significant deficits, and thus, do not justify the promulgation of a "uniform" living will law at this time. The principal intended benefit is to protect the rights of incompetent patients who do not wish their lives prolonged by medical treatment. A secondary benefit is to assist physicians in making difficult decisions to terminate treatment. Knowledge that a particular course of action "is

79. Paul Ramsey, in commenting upon the California Natural Death Act, stresses the importance of the stringent definition of terminal condition to apply only to those patients whose death is imminent "regardless of the application of life-sustaining procedures." P. RAMSEY, *ETHICS AT THE EDGES OF LIFE* 325-26 (1978). Ramsey suggests that, in the context of the California statute, this requirement "may say too much." *Id.* at 327. However, the URTIA differs from the California act in its definition of terminal condition, which is a salient component of Ramsey's analysis. Whereas removal of treatment under the California act "is anchored in a physician's reasonable certainty of the objective fact that death is imminent," *Id.*, the URTIA specifically rejected "imminency" language and, instead, defined a terminal condition as one which will bring about death within a "relatively short time." URTIA, *supra* note 41, § 1(9), § 1 comment. This term is sufficiently ambiguous so as to potentially enlarge the category of patients well beyond that embraced in the California act.

80. The opinion of the Appellate Division in *Conroy*, which was later reversed by the New Jersey Supreme Court, held that removal of a feeding tube from a non-comatose patient whose death was not imminent would constitute euthanasia. *In re Conroy*, 190 N.J. Super. 453, 475-76, 464 A.2d 303, 315 (1983), *rev'd*, 98 N.J. 321, 486 A.2d 1209 (1985). The trial court in *Brophy v. New England Sinai Hosp., Inc.*, No. 85E0009-G1 (Mass. Probate Ct., Norfolk, Oct. 21, 1985) *rev'd in relevant part*, No. 4152 (Mass. Sup. Jud. Ct. Sept. 11, 1986), held that removal of a feeding tube from a non-dying patient in a persistent vegetative state would be unethical and contrary to public policy against euthanasia. Slip. op. at 42.

what the patient would have wanted" may mean more to the physician and nursing staff than any form of legal immunity granted by the living will statute. These benefits accrue, however, only if the patient has signed a living will. Even in such cases, the non-specific nature of the living will with regard to particular treatments may render the document almost useless as an instrument of patient autonomy. In sum, the benefits provided by current living will legislation to medical decision-making could be securely obtained through improvements in patient-physician communication, modification of hospital policies towards care of the chronically and terminally ill, and legislation which provides a more balanced approach to the problems of such patients, alternatives which do not weaken existing legal strictures against euthanasia.⁸¹

4. Legislative Alternatives to the Living Will

Despite the shortcomings of the URTIA and other living will legislation, there is a place for legislation on the medical treatment of the terminally ill. As courts have recognized, the legislature is a more appropriate forum for the competing claims of private rights and public interests that are at issue.⁸² The legislature ought to be encouraged to take this role seriously, and consider a variety of approaches to protect the rights and interests of patients, and to clarify the legal status of euthanasia. In addition, the legislature maintains an inherent capacity for self-correction that is not as evident in the judiciary. Finally, as discussed in the next section of this article, court decisions in many ways pose a greater threat to existing prohibitions on euthanasia than does living will legislation. As theologian Paul Ramsey has noted, "(l)egislation is our last resort if I am correct in believing that the common law's ancient protection of life—against any private decision makers and against any consensus—is eroding."⁸³

It is beyond the scope of this article to propose compre-

81. The President's Commission concluded that the "greatest value" of living will legislation was the impetus it provided to patient-physician communication. "This educational effect might be obtained, however, without making the documents binding by statute and without enforcement and punishment provisions." REPORT OF THE PRESIDENT'S COMMISSION, *supra* note 23, at 145. Adoption of this recommendation of the Commission would satisfy most of the arguments presented in this article against living will statutes.

82. See, e.g., *John F. Kennedy Memorial Hosp. v. Blutworth*, 452 So. 2d 921 (Fla. 1984).

83. P. RAMSEY, *supra* note 79, at 330.

hensive legislative reform in the area of medical treatment of the terminally ill and chronically impaired. We use the term "reform" with some caution, because what is needed is a comprehensive strengthening of existing legal rights and obligations. The medico-legal challenge in this debate is not, as is so often said, to overcome the failure of the law to keep pace with medical technology. The challenge is to prevent the dilemmas of medical decision-making from forcing upon us undesirable changes in the law. None of these dilemmas are so difficult or so foreign to traditional medical ethics that they confound existing legal doctrines.⁸⁴ Yet, for various reasons, these doctrines are considered obsolete, and doctrines which provide a legal basis for euthanasia are being erected in their place.⁸⁵

Legislation will inevitably be needed to halt this ill-founded legal reform. We suggest the following categories for legislative activity. Some are discrete statutory schemes; others may be accomplished by amendment of existing statutes.

a. Protection of Vulnerable Adults

One area of social change which has been inadequately addressed by legislation is the phenomenon of elderly, impaired patients, lacking frequent family contact, who reside in nursing homes. This is a problem that did not exist in its current proportions a generation ago, and one that will expand by the turn of the century and beyond. Such persons are vulnerable medically because they are seen by physicians infrequently, vulnerable socially because they are cut off from a family environment and other stimuli, and vulnerable politically because they have no capacity of their own to influence the many governmental decisions which affect their lives.

Although legislation to reform the nursing home industry is helpful, our proposal is that states go further to establish offices for the protection of individual nursing home patients, and other vulnerable adults. The Minnesota Vulnerable Adults Protection Act⁸⁶ might be considered as a model of such legislation. Under this legislation, private complainants may initiate an investigation of suspected abuse of

84. See Horan & Grant, *supra* note 39.

85. P. RAMSEY, *supra* note 79, at 294-95.

86. MINN. STAT. ANN. § 626.557 (West 1983).

adults.⁸⁷ Such procedures may be effective ways of deterring medical abuse without resort to adversarial proceedings. A similar approach has been enacted by Congress with respect to the medical treatment of handicapped infants. An alternative to the Minnesota legislation is that highlighted by the New Jersey Supreme Court in its *Conroy* opinion: an office of ombudsman for the institutionalized elderly. Under *Conroy*, the office of ombudsman, created by statute several years earlier, was granted a new authority: to investigate and file a report in cases where life-prolonging medical treatment is sought to be withdrawn from terminally ill nursing home patients.⁸⁸

Conceivably, such legislation could be used not only to reinforce legal protection for the elderly, but to investigate, and deter, true instances of over-treatment of the elderly. If a patient's bodily integrity or dignity were being violated by overly aggressive medical treatment, an appropriate complaint could be filed with an ombudsman, who would then investigate and make recommendations. Contested cases could be resolved in court, or through an "ethics committee" mechanism similar to that recommended for infant treatment controversies.⁸⁹

b. Establish Minimal Care Guidelines

A legitimate concern raised by the URTIA is that it provides no basic level of care that must be provided to patients in all circumstances. With the advent of the debate over whether nutrition and hydration are required in all cases, there is little consensus on this issue. Yet, the lack of consensus should not stay the legislature's hand; a similar circumstance prevailed on the issue of treatment for handicapped infants and was resolved largely as a result of the public interest stirred by the case of Infant Doe in Bloomington, Indiana.⁹⁰

The Child Abuse Amendments of 1984,⁹¹ pertaining to the Infant Doe issue, offer guidance for creating a base stan-

87. *Id.* § 626.557 Subd. 3.

88. 98 N.J. at 378-85, 486 A.2d at 1239-42.

89. See Services and Treatment for Disabled Infants; Model Guidelines for Health Care Providers to Establish Infant Care Review Committees, 50 Fed. Reg. 14,893 (1985).

90. See Horan & Balch, *Infant Doe and Baby Jane Doe: Medical Treatment of the Handicapped Newborn*, 52 LINACRE Q. 45, 50 (1985).

91. *Supra* note 8.

dard of medical care. Under these amendments, beneficial medical treatment must be provided to any infant unless 1) the infant is chronically and irreversibly comatose; 2) the provision of such treatment would merely prolong dying or be otherwise futile in terms of survival; and 3) the provision of treatment would be futile and the treatment itself would be inhumane under the circumstances.⁹² Even under these exceptions, however, a patient cannot be denied "appropriate nutrition, hydration and medication."⁹³ This standard provides a workable foundation for a proper standard of care towards terminally ill adults.

The law currently recognizes that medical treatment need not be provided to patients who meet any of the three categories of exceptions.⁹⁴ There is growing ambiguity, however, regarding the obligation to provide appropriate nutrition, hydration and medication.⁹⁵ Enactment of such a baseline standard need not create an absolute requirement to provide nourishment, by whatever method, to every patient. There are narrowly prescribed circumstances where the means of providing nutrition and hydration are not *medically* appropriate.⁹⁶ In order to draw the line against euthanasia by starvation, the law should insist that any decision to forego nutrition and hydration be strictly justifiable by medical criteria: impossibility, imminent death which makes surgical intervention inappropriate, futility due to inability to metabolize or otherwise benefit from nutrition.⁹⁷ In addition to appropriate nutrition and medication, such legislation ought to mandate other measures needed for the comfort and personal dignity of patients: personal hygiene care, turning to prevent bedsores, adequate warmth.

92. 45 C.F.R. § 1340.15(b)(2) (1985).

93. *Id.*

94. *See generally* Horan & Grant, *supra* note 39.

95. *See supra* notes 70-76 and accompanying text.

96. "We recognize that in rare cases, the provision of fluids and, particularly, nutritional support may be medically futile or even counterproductive in sustaining life. We do not recommend that such futile or counterproductive steps be mandated." Siegler & Weisbard, *supra* note 48, at 130.

97. This is virtually identical to the standard enunciated by the trial court in *Brophy v. New England Sinai Hosp. Inc.*, No. 85E0009-G1 (Mass. Probate Ct., Norfolk, Oct. 21, 1985), *rev'd in relevant part*, No. 4152 (Mass. Sup. Jud. Ct. Sept. 11, 1986).

c. Protect the Right to Consent to Treatment

The right of an adult to express, while competent, his preferences for medical treatment in event of incompetency and terminal illness is secured by the common law⁹⁸ and, possibly, by the constitutions of the states and the federal government.⁹⁹ The central premise of living will legislation, therefore, is in some respects a restatement of existing law. However, living will legislation inadequately protects the rights of patients in this area. These rights must include the right to request all appropriate medical interventions, as well as the right to refuse treatment. Thus, legislation and suggested directives should provide a broader range of options to prospective signers of the living will than presently exists. Moreover, patients should be protected against the unforeseen consequences of a living will that is signed without knowledge of the nature of the medical condition and treatment in question. A patient's directives should not be cavalierly ignored, but neither should they be used to bring about the suspension of all treatment where the directive was made without knowledge of the present condition. Several states have made living will documents advisory to physicians, which seems to be a preferable approach.¹⁰⁰ A physician should be granted immunity only for good-faith, medically appropriate decisions made under the aegis of such a document. Even greater reliance, of course, can be placed on the directive of a patient who, at the time of executing a directive, had knowledge of the nature of his condition and of treatment alternatives.

There are clearly other areas in which legislation could be beneficial, many of which will become apparent after greater experience. We hope the preceding discussion has established that there are legislative mechanisms available to provide a greater balance than that present in the current scheme of living will legislation. The existing statutes may eventually be seen as the first step in a long process of legisla-

98. BYRN, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 2-16 (1975).

99. *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663-64, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976).

100. NEV. REV. STAT. § 449.640 (1977) (the physician shall "give weight" to the patient's declaration, but may consider other factors in deciding whether to withdraw treatment); N.C. GEN. STAT. § 90-321(c) (1985) (the attending physician "may rely" upon a declaration expressing a desire not to have life prolonged).

tive activity in this area. It is certain that advocates of euthanasia view the living will as a first step; whether it constitutes a first step towards euthanasia or not depends upon the willingness of other political forces to use the legislative process to work against such a development.

III. EUTHANASIA AND THE COURTS

A. *Quinlan* and *Conroy*

The decision of the New Jersey Supreme Court in 1976 to permit the withdrawal of a mechanical respirator from Karen Quinlan remains, ten years after its writing, the single most important American legal authority on the subject of euthanasia.¹⁰¹ With one notable exception,¹⁰² state courts addressing the question have accepted the *Quinlan* doctrine that the constitutional right to privacy protects the right of an incompetent patient to "decide" to forego medical treatment, even if the patient is not capable of communication and has left no clear indication of what her decision would be.¹⁰³

The implications of this doctrine on the legal status of euthanasia, however, have not always been clearly understood. A number of commentators called the opinion a clear step towards the legalization of euthanasia.¹⁰⁴ Others were more cautious in their criticism, pointing out that although the constitutional basis for the relief granted to Joseph Quinlan was dangerously broad, the actual order of the New Jersey Supreme Court was carefully circumscribed, and could have been supported by far less adventurous legal reasoning.¹⁰⁵

101. Kamisar, *The Real Quinlan Issue*, N.Y. Times, June 17, 1985, at A19, col. 1.

102. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

103. *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *John F. Kennedy Memorial Hosp. v. Blutworth*, 452 So. 2d 921 (Fla. 1984); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983), *modified*, *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

104. P. RAMSEY, *supra* note 79, at 294. ("The *Quinlan* case has gone a long way toward obliterating the distinction between voluntary and involuntary euthanasia and weakening legal protection of life from involuntary euthanasia.") See also Kamisar, *supra* note 101, at A19.

105. Horan, *The Quinlan Case*, in DEATH, DYING AND EUTHANASIA

Whether or not the treatment of Karen Quinlan constituted euthanasia, or was otherwise improper, there is increasing support for the conclusion that, on balance, the *Quinlan* opinion has weakened legal and ethical prohibitions against euthanasia. Professor Kamisar has been among the leading critics of the opinion on this score. *Quinlan* served the cause of euthanasia, in his view, by enunciating a legal doctrine that would inextricably link "voluntary" euthanasia (the professed public policy goal of the supporters of euthanasia) with involuntary euthanasia.¹⁰⁶ *Quinlan* forged this link between the "right to die" and the "right to kill" by defining the incompetent patient's constitutional rights of personal autonomy to include a right to refuse life-preserving medical treatment,¹⁰⁷ by ruling that this right could be exercised on behalf of the incompetent patient by a family member or guardian,¹⁰⁸ and by holding that in cases of severe disability, such as Miss Quinlan's, the state interest in preserving life could not check the guardian's exercise of the patient's "privacy" rights.¹⁰⁹

The implications of this series of rulings for existing laws against euthanasia are self-evident. If a "right to die" is given constitutional protection, and if that right can be "exercised on behalf of" an incompetent patient by imputing to that patient the desire to die, then all persons have a right to receive "voluntary" euthanasia—whether or not they actually request it.¹¹⁰ *Quinlan*, therefore provides a legal scheme by which the legalization of voluntary euthanasia will inevitably lead to the practice of all forms of euthanasia. Qualms regarding the practice of euthanasia could be satisfied, in each case, by completing the ritual of "imputing" the will of the patient to choose euthanasia. In that way, every act of euthanasia could be considered "voluntary," at least by those willing to be so comforted.

Further evidence of the danger *Quinlan* poses to existing laws against euthanasia may be surmised from the court's discussion of whether the death of Karen Quinlan upon removal of the respirator would constitute a homicide. The court answered that insofar as the death resulted from existing natural causes—Karen's inability to breathe—it would not consti-

525, 526 (2d ed. 1980).

106. Kamisar, *supra* note 101.

107. 70 N.J. at 40, 355 A.2d at 663-64.

108. *Id.* at 37, 355 A.2d at 662.

109. *Id.* at 41, 355 A.2d at 664.

110. P. RAMSEY, *supra* note 79, at 292-97.

tute homicide. "[E]ven if it were regarded as homicide," the court continued, "it would not be unlawful,"¹¹¹ presumably because it would be exonerated under the constitutional right to privacy.¹¹² The court's reading of the right to privacy, therefore, encompasses constitutional protection for intentional acts of killing. Accordingly, the avenue of constitutional rights emerged from *Quinlan* as the most direct route to avoid the application of homicide laws to acts of euthanasia.

The decision in *Conroy* suggests that the New Jersey court is uncomfortable with the expansiveness of the doctrines enunciated in *Quinlan*. In *Conroy*, the court set out to create new legal standards to govern medical treatment decisions for a particular class of patients: elderly, formerly competent nursing home residents who are severely impaired and have a relatively short life span, but are not imminently dying or comatose.¹¹³ In creating these standards, the court affirmed that the right to refuse life-sustaining treatment is protected under the common law, although it did not specifically hold, as did *Quinlan*, that the right is protected under constitutional law as well.¹¹⁴ However, *Conroy* departs rather sharply from *Quinlan* on the question of patient autonomy in circumstances where an incompetent patient has left no clear directive regarding medical treatment. Moreover, *Conroy* imposes procedural safeguards on the withdrawal of treatment that are far more draconian than those set forth in *Quinlan*. These safeguards imply that the court is cognizant of the close relationship between the withdrawal of life-sustaining treatment and euthanasia.¹¹⁵

Under *Quinlan*, the constitutional right of privacy applied regardless of whether the patient's specific wishes regarding medical treatment were known. *Quinlan* permits the treatment decision to be made by a guardian acting on behalf of the incompetent person under the principle of substituted judgment.¹¹⁶ After ruling that Karen's family should have the right to decide whether Karen would choose to remain on the respirator, the *Quinlan* court stated that "this decision should be accepted by a society the overwhelming majority of

111. 70 N.J. at 51, 355 A.2d at 670.

112. *Id.* at 51-52, 355 A.2d at 670.

113. 98 N.J. at 342, 486 A.2d at 1219-20.

114. *Id.* at 348, 486 A.2d at 1223.

115. *See infra* text accompanying notes 128-34.

116. 70 N.J. at 42, 355 A.2d at 662.

whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them."¹¹⁷

The *Conroy* court took a very different view.

Many people may have spoken of their desires in general or casual terms, or, indeed, never considered or resolved the issue at all. In such cases, a surrogate decision-maker cannot presume that treatment decisions made by a third party on the patient's behalf will further the patient's right to self-determination, since effectuating another person's right to self-determination presupposes that the substitute decision-maker knows what the person would have wanted. Thus, in the absence of adequate proof of the patient's wishes, *it is naive to pretend that the right to self-determination serves as the basis for substituted decision-making.*¹¹⁸

As an alternative to substituted judgment, the court established three tests under which decisions can be made to withdraw life-sustaining treatment from patients in Miss Conroy's circumstances: a "subjective" test; a "limited-objective" test; and a "pure-objective" test. In every case of the withdrawal of life-preserving treatment from a terminally ill nursing home resident, the court ruled, one of the three tests must be applied. Consistent with its reliance upon patient autonomy as the guiding principle in such cases, the court indicated that the choice of which test to apply depends upon whether the patient has made a prior statement on the issue, and the precise content and circumstances of that statement.

Under the subjective test,

life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved. The standard we are enunciating is a subjective one, consistent with the notion that the right we are seeking to effectuate is a very personal right to control one's own life. The question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself.¹¹⁹

Evidence of the patient's intent can be established by written

117. *Id.* at 41-42, 355 A.2d at 662.

118. 98 N.J. at 364, 486 A.2d at 1231 (emphasis added).

119. *Id.* at 360-61, 486 A.2d at 1229.

documents, oral statements, or actions.¹²⁰ The probative value of such evidence, the court ruled, will depend upon the "remoteness, consistency and thoughtfulness" of the prior statements, as well as their specificity regarding "the level of impaired functioning and forms of medical treatment that one would find tolerable"¹²¹ In addition, the medical evidence must establish that the patient is "an elderly, incompetent nursing-home resident with severe and permanent physical and mental impairments and a life expectancy of approximately one year or less."¹²²

Outside of the subjective test, decisions to remove life-sustaining treatments are severely restricted by *Conroy*. Under the limited-objective test, such treatments can be withheld from a patient in Claire Conroy's condition if there is "some trustworthy evidence" that the patient would have refused the treatment, and "the decision-maker is satisfied . . . that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him."¹²³ However, the benefits and burdens that may be taken into account are restricted.

By this we mean that the patient is suffering, and will continue to suffer throughout the expected duration of his life, unavoidable pain, and that the net burdens of his prolonged life (the pain and suffering of his life with the treatment less the amount and duration of pain that the patient would likely experience if the treatment were withdrawn) markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life.¹²⁴

Finally, under the pure-objective test, life-sustaining treatment can be withdrawn from an incompetent patient when the burdens of life—again defined as pain and suffering—outweigh the benefits, and when the further provision of life-sustaining treatment "would be inhumane."¹²⁵ No subjective evidence of the patient's desires is necessary under this test.¹²⁶

The standards just outlined define the categories of pa-

120. *Id.* at 361, 486 A.2d at 1229-30.

121. *Id.* at 362, 486 A.2d at 1230.

122. *Id.* at 363, 486 A.2d at 1231.

123. *Id.* at 365, 486 A.2d at 1232.

124. *Id.*

125. *Id.* at 366, 486 A.2d at 1232.

126. *Id.*

tients from whom treatment can be withdrawn. The court also enunciated procedural safeguards to ensure that such decisions are made only in cases of duly-qualified patients.

1. There must be clear and convincing evidence that the patient does not have and never will regain the capacity to make decisions for himself. This evidence must be provided by at least two physicians with appropriate qualifications who have personally examined the patient.¹²⁷

2. Whenever a decision to remove treatment under either of the three tests is contemplated, notice must be given to the Office of the Ombudsman for the Institutionalized Elderly. The ombudsman must take evidence from the attending physician and nursing staff, and arrange for an independent medical examination by two physicians.¹²⁸

3. If all of the physicians corroborate the medical diagnosis, if the ombudsman concurs, and if one of the three tests is satisfied, the guardian may then decide to withhold or withdraw life-sustaining treatment. In cases where the limited-objective or objective test is employed, the family of the patient must also concur in the decision.¹²⁹

The *Conroy* opinion clearly illustrates the difficulty of placing limits on any form of legalized euthanasia. Under the subjective test, the court has arguably legalized certain forms of passive euthanasia. A person who has executed a specific directive, and who is suffering from a terminal illness that will cause death within a year, may be removed from all medical interventions, even from mechanical feeding. There does not appear to be any countervailing state interest which may interfere with this decision, and the ombudsman is apparently bound to honor it unless there is evidence of fraud.¹³⁰

Having legalized passive euthanasia for this small category of patients, the court created an elaborate set of restrictions to prevent euthanasia from being practiced upon other patients. The requirement that patients under the remaining two tests be in unremitting pain effectively removes a large number of potential candidates for euthanasia, including Claire Conroy, the patient whose treatment was at issue. In addition, the requirements, if followed, will make it more difficult for physicians to make any decision concerning life-sus-

127. *Id.* at 382, 486 A.2d at 1241.

128. *Id.* at 383-84, 486 A.2d at 1241-42.

129. *Id.* at 384-85, 486 A.2d at 1242.

130. *Id.* at 385, 486 A.2d at 1242 (noting that ombudsman may refer cases of questionable criminal abuse of patients to county prosecutor).

taining treatment for a patient in Miss Conroy's condition. For example, a decision to follow a non-aggressive treatment plan for a patient in the circumstances of Miss Conroy may include a decision to withhold certain forms of life-sustaining treatment.¹³¹ If all such decisions are subject to the *Conroy* requirements for second medical opinions, and investigation by the ombudsman, the burdens upon medical practice could be profound. Thus, by eradicating the potential for abuse of the limited right to euthanasia that is created by *Conroy*, the court may have unduly disturbed the process of making perfectly valid decisions to forego aggressive therapy upon the terminally ill. Professor Kamisar wrote that it is practically impossible to write euthanasia legislation that will both protect the right to euthanasia for those of sound mind who request it, and prevent abusive practices.¹³² This thesis is borne out by the complex procedures set forth in the *Conroy* opinion.¹³³

131. See *Brophy*, No. 85E0009-G1 slip op. at 18-21 (Mass. Probate Ct., Norfolk, Oct. 21, 1985), *rev'd in relevant part*, No. 4152 (Mass. Sup. Jud. Ct. Sept. 11, 1986).

132. Kamisar, *supra* note 1, at 978-81.

133. One member of the New Jersey court agreed that the procedures established in *Conroy* are too cumbersome to be of practical use. Although he concurred in the result, Justice Handler indicated in his separate opinion that he would analyze the case from a different starting point than that chosen by his colleagues, and arrive at a different result. The proper starting point, he said, is not the doctrine of patient autonomy, but that of patient "best interest." 96 N.J. at 392-93, 486 A.2d at 1246-47 (Handler, J., concurring in part and dissenting in part). It would be "amiss," Justice Handler stated, to stress notions of personal autonomy in the context of Miss Conroy's situation. *Id.*, 486 A.2d at 1246. Reliance upon personal autonomy cannot help address the situation, because such patients have lost the ability to choose. As an alternative to notions of privacy and autonomy, Justice Handler proposed that these cases be guided by the court's application of equitable principles. *Id.* at 393, 486 A.2d at 1246-47.

Justice Handler's application of equity to this case could achieve a legal result that is both less intrusive and less prone to creating a risk of euthanasia. He would apparently limit the withdrawal of life-saving treatment to patients who are truly *in extremis*.

The person should be terminally ill and facing imminent death.

There should also be present the permanent loss of conscious thought processes in the form of a comatose state or profound unconsciousness. Further, there should be the irreparable failure of at least one major and essential bodily organ or system.

Id. at 398, 486 A.2d at 1249. Justice Handler would permit a wider range of criteria to influence a decision to withdraw treatment: in addition to physical pain, he would consider overall physical condition and deterioration, as well as sensory, emotional, and cognitive functioning. *Id.* at 397-98, 486 A.2d at 1249.

B. *Bouvia* and *Jobes*

Judicial developments in the wake of *Conroy*, have, as some had feared, largely ignored the carefully wrought safeguards of that opinion, and have expanded legal protection for acts of euthanasia by omission of nourishment and fluids. These developments, if unchecked, are likely to destroy the tenuous balance arrived at in the years since *Quinlan* between the right of the terminally ill individual to refuse life-prolonging medical treatment, and the interests of society in maintaining a strict legal standard against euthanasia.¹³⁴ Indeed, the increasingly prevalent judicial opinion is that, in the case of certain patients, there is no state interest in the preservation of life, and hence, no state interest in prohibiting at least passive acts of euthanasia. Continued acceptance of this trend will cause a fundamental re-alignment in American law similar to that caused on the question of abortion by *Roe v. Wade*.¹³⁵ Just as *Roe* has made it exceedingly difficult for states to limit in any way the practice of abortion, these decisions may eventually render the state incapable of effectively proscribing euthanasia.

In the case of *In re Jobes*,¹³⁶ a New Jersey Superior Court judge granted the petition brought by the husband of a 31-year old, severely brain damaged woman, to remove the jejunostomy tube through which liquid nourishment is provided

Despite enlarging upon the "quality of life" factors that the majority would consider acceptable, Justice Handler's approach, if it were strictly applied and if adequate enforcement ability were in place, could avoid many of the dangers inherent in the majority's opinion. For example, the majority would permit the withdrawal of treatment from any patient with a life expectancy of one year or less—an expansive and imprecise period that could encourage the rendering of ill-founded patient prognoses. The standard of "imminently dying" proposed by Justice Handler, if not absolutely precise, at least establishes a period that is much shorter than one year, and thus, a period of life expectancy about which a more confident prognosis may be made. Furthermore, the very cumbersomeness of the safeguards proposed by the majority are likely to be a disincentive to compliance on the part of health-care providers, and serve to perpetuate the myth that the law is incapable of offering sound and practical guidance in these areas. Justice Handler's opinion is not perfect, and may carry its own blind spot to the dangers of euthanasia's "slippery slope," but after pouring through the contortions of the majority opinion, it has a healthy ring of common sense to it.

134. See, Horan & Grant, *Prolonging Life and Withdrawing Treatment: Legal Issues*, 50 *Linacre Q.* 153, 166-68 (1983).

135. 410 U.S. 113 (1973).

136. No. C-4971-85E (N.J. Super Ct. Chancery Div., Morris County, Apr. 23, 1986).

to her. As stated succinctly in the opinion of the court, "[i]f the feeding tube is removed, dehydration and starvation will follow, and Ms. Jobses will die. If feeding continues, she will live indefinitely."¹³⁷ The court authorized the husband to direct the removal of the feeding tube, finding

by clear and convincing evidence that Nancy Ellen Jobses is in a persistent vegetative state; that, if competent, Ms. Jobses would not want to be sustained in this mental and physical condition by artificial tube feeding, and that the plaintiff is a suitable person . . . to carry out his wife's wishes with respect to the discontinuance of feeding through artificial means.¹³⁸

Because the condition of Nancy Jobses was different from that of Claire Conroy, and the treatment in question was different from that which was sought to be removed from Karen Quinlan, the *Jobses* opinion was, of necessity, a tapestry reflecting elements of both *Conroy* and *Quinlan*. It remains to be seen whether the New Jersey Supreme Court will choose to reweave the trial court's handiwork, but there are several questions in the case which might merit the type of plenary review the New Jersey Supreme Court seems prone to engage in when faced with a case of this variety.¹³⁹

137. *Id.*, slip op. at 1.

138. *Id.* at 2-3.

139. Among the more controversial aspects of the *Jobses* opinion are its resolution of conflicting medical evidence on the precise nature of Ms. Jobses' neurological impairment, its adoption of somewhat vague prior statements by Ms. Jobses as "clear and convincing evidence" of a prior intent to renounce artificial feeding, and its decision to permit the withdrawal of feeding despite the prognosis of indefinite lifespan, a factor that was present neither in *Quinlan* nor in *Conroy*.

As the court acknowledged, the five expert physicians who examined Mrs. Jobses "disagree[d] sharply about her ability to follow simple commands." *Id.* at 6. Three of the doctors, Henry R. Liss, Fred Plum, and David Levy, testified that they were unable to elicit anything other than a startle response from Mrs. Jobses. This would be consistent with a diagnosis of "persistent vegetative state," described by the court as a state where a person is "permanently devoid of all cognitive functions." *Id.* at 5. Two other physicians of equivalent credentials, Maurice Victor and Allan Ropper, claimed that they were able to elicit responses to commands from Mrs. Jobses, and thus concluded that, while severely brain-damaged, Mrs. Jobses is not in a persistent vegetative state. *Id.* at 8. In addition to the testimony of Ropper and Victor, several members of the nursing home staff testified that they were able to elicit responses from Mrs. Jobses showing evidence of cognitive activity.

The trial court resolved this dispute by noting that "all of the witnesses who claimed to elicit command responses from Ms. Jobses . . . believe that

The decision of the California Court of Appeal panel in *Bouvia v. Superior Court*¹⁴⁰ constitutes the most forthright judicial acknowledgment yet of the "right" to undergo euthanasia by omission. Ms. Bouvia had achieved notoriety when her earlier petition to compel a private hospital to permit her to starve herself to death while under the hospital's care was rejected.¹⁴¹ After reportedly renouncing her suicidal intent, Ms. Bouvia, a quadriplegic afflicted with severe cerebral palsy, experienced difficulty in finding a suitable living arrangement.¹⁴² In her most recent petition, to prevent a public hospital from feeding her through a naso-gastric tube, it is not clear whether Ms. Bouvia wishes to die, since she consumes a partial liquid diet.¹⁴³ Ms. Bouvia is reportedly in con-

it is a violation of professional ethics and personal morality to withhold or withdraw tube feeding Their sincere opposition to the withholding of nutrition from any patient . . . have caused them to see signs of intelligence where no such intelligence exists." *Id.* at 9. The court's finding of bias is curious, because each of the physicians who testified that there was no response to commands stated an equally strong opinion that the feeding tube should be removed from Mrs. Jobs. Why the position of an eminent physician on the ethics of removing feeding should disqualify that expert only if he is opposed to removing feeding is a rule of evidence not fully explicated by the trial court.

An appellate court in *Jobs* will also have to square the trial court's finding that the prior statements made by Mrs. Jobs on the subject of medical treatment, none of which mentioned artificial feeding in particular, could rise to the level of "clear and convincing evidence" of her intent to forego tube feeding. *Id.* at 9. At another point in the opinion, the court appears to backtrack from this holding, stating that Mrs. Jobs fits the "limited objective" test under *Conroy*. See *supra* note 123. If this is the case, then an appellate court may review the trial court's finding that *Conroy's* restriction on withdrawal of treatment under the limited-objective test to terminally ill patients in unremitting pain should not prevent the relief sought by the family of Mrs. Jobs. The trial court has effectively expanded *Conroy* and *Quinlan* to a factual situation, the non-terminal but profoundly impaired patient, that was not contemplated by the New Jersey Supreme Court in either of the two prior cases. In *Quinlan*, of course, the patient unexpectedly lived for nine years *after* removal of the respirator. However, the underlying assumption of the Supreme Court opinion in *Quinlan* was that Miss Quinlan's prognosis for life was poor, and that she was slipping closer to death with each passing day. 70 N.J. at 57. Although this turned out not to be the case, one cannot presume that the rule established in *Quinlan* was intended to apply to the different set of factual circumstances presented by the condition of Mrs. Jobs.

140. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

141. *Bouvia v. County of Riverside*, No. 159780 (Cal. Super. Ct., Riverside Dec. 16, 1983), Record vol. 9 at 1238-50.

142. *Bouvia v. Superior Court*, 225 Cal. Rptr. at 300.

143. *Id.*

stant pain for which she is administered morphine.¹⁴⁴

Regardless of the precise nature of Ms. Bouvia's intent, the opinion of the Court of Appeal is clearly broad enough to impart to Ms. Bouvia an absolute constitutional right to refuse medical treatment, including nutrition and hydration, even if the effect of that refusal is to commit suicide. "The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged."'¹⁴⁵ The court rejected the contention that Ms. Bouvia's right ought to be limited by the state interests in the preservation of life and the prevention of suicide.

Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's [sic] alone.¹⁴⁶

The court likewise concluded that it is acceptable for Ms. Bouvia to make a decision that will hasten death on the basis of her perception of a poor quality of life.

Although alert, bright, sensitive, perhaps even brave and feisty, she must lie immobile, unable to exist except through physical acts of others. Her mind and spirit may be free to take great flights but she herself is imprisoned and must lie physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness. We do not believe it is the policy of this State that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure, for "15 to 20 years."¹⁴⁷

The court deemed the state interest in preventing death by suicide to be irrelevant, and indeed, posited that the right to suicide may be included in the constitutional right to

144. *Id.*

145. *Id.* at 304 (quoting *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220 (1984)).

146. *Id.* at 305.

147. *Id.*

privacy.¹⁴⁸

The concurring opinion of Justice Compton went further, holding that there is a fundamental and absolute right to commit suicide, and to demand the assistance of others, including the medical profession, if one is unable to perform the act.

Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless and, to her, intolerable condition. I believe that she has an absolute right to effectuate that decision. This state and the medical profession instead of frustrating her desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane.

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.¹⁴⁹

In the opinion of Justice Compton, the medical profession should have no qualms in acceding to the requests of individuals for euthanasia or assisted suicide, as long as the threat of legal liability is removed. Although the Hippocratic Oath expressly states: "I will give no deadly medicine to anyone if asked," Justice Compton notes that the medical profession "has already accommodated a deviation from that part of the [Hippocratic] oath" that proscribed induced abortion.¹⁵⁰ Presumably, in Justice Compton's view, the accommodation of medicine to legalized euthanasia and suicide would be no more difficult to achieve.

The line of California cases culminating in *Bouvia*¹⁵¹ leaves that state with, at best, a very fluid public policy towards euthanasia, and, at worst, a policy that is openly in favor of mercy-killing. Society should take note that the most aggressive statement of an absolute right to die has emerged

148. *Id.* at 306. ("[A] desire to terminate one's life is probably the ultimate exercise of one's right to privacy.")

149. *Id.* at 307. (Compton, J., concurring).

150. *Id.* at 308.

151. *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1984).

in a case not involving an elderly, terminally ill patient, or a comatose patient, but a person who is found to be rational and competent. The court's justification for euthanasia in the case of Elizabeth Bouvia is that she suffers from a severe handicap. The court's characterization of the quality of Ms. Bouvia's existence as inhumane and intolerable opens the door for similar negative quality of life assessments for other persons with disabilities. Although Ms. Bouvia suffers great physical pain, the court's quality-of-life judgment focused greater attention on the perceived "indignity" of being quadriplegic and thus requiring the assistance of others for basic bodily functions. The logical conclusion to draw from *Bouvia* is that, at least in the eyes of this particular appellate panel, a state policy which holds life to be of intrinsic value regardless of handicap or other impairment is irrational and will not be permitted to stand against the right to terminate life. This is a sufficient doctrinal foundation for the legalization of euthanasia.

Although *Bouvia* does not create a point of no return in the development of legal doctrine on euthanasia, we have clearly reached a juncture where jurists, physicians and society can no longer avoid confrontation on the legality and morality of mercy-killing. Prior to *Bouvia* and *Jobes*, it was possible to hope that the damage caused to our public policy against euthanasia and mercy-killing by the current debate over the provision of life-sustaining treatment might be controllable. The courts had generally recognized the importance of the state interests involved, and had created safeguards to limit the application of the right to refuse medical treatment. Now that these safeguards are being tossed aside, the hope for a legal, medical and ethical consensus against mercy-killing is fleeting.¹⁵²

152. In addition to the opinions discussed, significant rulings have appeared in *Brophy v. New England Sinai Hosp., Inc.*, No. 85E0009-G1 (Mass. Probate Ct., Norfolk, Oct. 21, 1985), *rev'd in part*, No. 4152 (Mass. Sup. Jud. Ct. Sept. 11, 1986), and in *Corbett v. D'Allessandro*, No. 85-1052 (Fla. Dist. Ct. App., Apr. 18, 1986), *petition for review denied*, No. 68,817 (Fla. Sup. Ct., July 30, 1986). In *Corbett*, decided two days after *Bouvia* and five days prior to *Jobes*, the court reversed a trial court holding that the exclusion of nutrition and hydration from the definition of "life-prolonging procedure" under the Florida living will statute (*see* FLA. STAT. § 765.03(3) (1984)) precluded the withdrawal of a nasogastric tube from an elderly woman in a persistent vegetative state. The woman died just two days after the hearing in the trial court, and prior to the trial court ruling, but the courts nevertheless retained jurisdiction due to the nature of the issues. Slip op. at 2.

IV. CONCLUSION

Examination of living will legislation, and court decisions such as *Quinlan*, and *Conroy*, *Bouvia*, and *Jobes*, reveal the complexity of the task of restricting euthanasia. The legal issues involved are numerous, and include two of the most fundamental aspects of the rule of law: the protection of life and the integrity of personal decision-making. Compounding these legal issues are ever-changing social and medical parameters.

The difficulty of the endeavor, however, should not stint the effort to uphold, preserve, and strengthen existing legal prohibitions against euthanasia. The testimony of Dr. Alex-

The court of appeals held that under Florida law, the right of a terminally ill patient to refuse life-sustaining medical treatment includes the right to refuse artificial means of nutrition and hydration. The court did not display rigorous examination of the issue, but nevertheless concluded: "We are unable to distinguish on a legal, scientific or a moral basis between those artificial measures that sustain life — whether by means of "forced sustenance" or "forced" continuance of vital functions — of the vegetative, comatose patient who would soon expire without the use of those artificial means." *Id.* at 6. *But see* discussion in notes 24 and 70, and text accompanying notes 69-72, *supra*. *Corbett* gives somewhat greater acknowledgment to the interests in preserving life that may be compromised by permitting decisions to remove food and water, but in the end, demonstrates a shallow understanding of the issue.

We forcefully affirm that Life having been endowed by our Creator should not be lightly taken nor relinquished. We recognize, however, that we are also endowed with a certain amount of dignity and the right to the "Pursuit of Happiness." When, therefore, it can be determined . . . that Life has, through causes beyond our control, reached the unconscious and vegetative state where all that remains is the forced function of the body's vital functions, including the artificial sustenance of the body itself, then we recognize the right to allow the natural consequence of the removal of those artificial life sustaining measures.

Slip op. at 7. Feeding, of course, does not constitute the "forced function" of a vital bodily function, whether nourishment is provided through the mouth or by other means. The *Corbett* court failed, as have other jurists, to explain why the assistance of medical and nursing personnel in supplying nourishment to a patient should make the provision of nourishment an optional measure. What started in *Quinlan* as license to withdraw invasive medical treatment when prognosis for life is dim has expanded to embrace the basic provision of nourishment. This is made evident by the divided, 4-3 opinion of the Massachusetts court in *Brophy*. The *Brophy* majority held that the distinctions drawn by the trial court, and by several parties and *amici*, between the provision of nutrition and of more evasive forms of life-support, are inconsequential. The *Brophy* dissenters strongly disputed this point, arguing that the majority opinion constituted an endorsement of suicide and euthanasia.

ander is more trenchant and relevant to American society than it was forty years ago. This testimony establishes that no just society can risk the profound evil of devaluing the life of any human being, no matter how profoundly that life may be impaired. Those who care for the terminally ill and the disabled, and those who face such impairments, are searching for more humane ways for persons to spend their last days in this life. There is, however, a continuing and ever-present danger that the quest for humane treatment may be infiltrated by the odious philosophy, in Dr. Alexander's words, "that there is such a thing as a life not worthy to be lived."

The danger of this philosophy to individual persons and to society is sufficiently great that all legal developments, such as the ones discussed in this article, ought to be carefully scrutinized to determine if they in any way contribute to its advance. Analysis of the URTIA and other living will legislation, as well as the opinions in *Quinlan*, *Conroy*, *Jobes*, and *Bouvia*, establishes that these developments may be used to advance the philosophy of euthanasia, and thus to weaken legal restrictions against it. The testimony of Leo Alexander establishes why developments that are so tainted ought to be resisted. Resistance, however, is not likely to be sufficient to accomplish the task of overcoming the "small beginnings" of euthanasia of which Leo Alexander has warned us. Indeed, such resistance will be futile unless effective legislative and judicial alternatives are constructed to resolve the social and political controversies which will continue to arise concerning our treatment of the aged, the terminally ill, and the severely impaired.