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Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations

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SURVEY

EUTHANASIA: CRIMINAL, TORT, CONSTITUTIONAL AND LEGISLATIVE CONSIDERATIONS

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EUTHANASIA: CRIMINAL, TORT, CONSTITUTIONAL AND LEGISLATIVE CONSIDERATIONS

I. Introduction

Euthanasia, which literally means happy death, is a broad term encompassing any killing done with the motive of relieving the victim of a painful or handicapped existence. It includes killings done at the express request of the victim, sometimes referred to as voluntary euthanasia, as well as killings done without the victim's consent, *i.e.*, involuntary euthanasia. Although euthanasia is generally associated with an affirmative act, such as a shooting or the injection of a lethal substance into a patient's body, the term is also used to describe mercy killings which are achieved by an omission to act, such as failing to continue necessary medical treatment. In this survey, the term euthanasia will be used in the broad sense, including all of the methods mentioned above.

Although discussions of euthanasia frequently focus on the moral issues involved, it is the intention of this survey to abstain from a moral treatment of the problem. Rather, the survey confines itself to an objective analysis of the criminal, tort and constitutional law presently applied to euthanasia, both in theory and in practice, and an examination of legislative attempts to restructure this body of law.

II. Criminal Law

There is little case law on the subject of euthanasia *per se*.[1] Prosecutions for euthanasia are rare, and those cases that do arise seldom result in convictions. Consequently, few appeals are taken and the courts are seldom afforded the opportunity to discuss the issue in written opinions. This does not mean, however, that the law regarding euthanasia is nebulous or embryonic. Despite the paucity of written decisions, the common law attitude towards euthanasia is clear—it is theoretically murder in the first degree.[2]

A. *The Common Law Tradition*

Every civilized legal system considers euthanasia a crime,[3] but few countries make it as serious an offense as does the Anglo-American common law. Many legal systems consider it a form of manslaughter[4] or make it a separate type of

1 Only one reported decision has used the term, and then only in dictum. People v. Conley, 49 Cal. Rptr. 815, 822, 411 P.2d 911, 918 (1966).

2 Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 970 at n.9 (1958); Orth, *Legal Aspects Relating to Euthanasia*, 2 MD. MED. J. 120, 127 (1953); N. ST. JOHN-STEVAS, EUTHANASIA, IN LIFE, DEATH AND THE LAW 262 (1961); Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 352 (1954).

3 N. ST. JOHN-STEVAS, *supra* note 2, at 264.

4 *See* Silving, *supra* note 2, at 363-68 for a discussion of the treatment of euthanasia under the German and Swiss legal systems.

homicide;[5] and at least one system regards euthanasia, in certain circumstances, as an offense punishable only by fine, if punished at all.[6]

To understand why the common law has judged euthanasia so severely, it is necessary to examine the common law attitude on the value of human life and the impact this has had on the development of the law of homicide. The common law regards life as sacred and inalienable,[7] and the criminal law reflects this basic philosophy. The common law defines murder as the killing of another human being with malice aforethought,[8] and because of the state's deep concern in the preservation of life, any such killing is regarded as murder "no matter how kindly the motive. . . ."[9] As long as the killing is done with malice, a term that has come to mean merely intent to kill or cause serious bodily harm,[10] the crime is murder.

> Thus, one who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief.[11]

In the first reported American case involving euthanasia, *People v. Kirby*,[12] defense counsel argued that the defendant who had drowned his daughter and stepson "because he thought it better for them to go into eternity than to stop in this world,"[13] could not be convicted of murder because "there was no evidence of malice against the children, but, on the contrary, it appeared he was much attached to them."[14] The court rejected this interpretation of malice, however, and stated that:

> [e]very willful and intentional taking [of] the life of a human being, without a justifiable cause, is murder, if done with deliberation and not in the heat of passion, and legal malice is always implied in such cases.[15]

Many European legal systems regard motive as a substantive element or mitigation of homicide,[16] but the common law absolutist approach has never recognized motive as a defense to a charge of murder.

If the proved facts established that the defendant in fact did the killing will-

5 The Polish Penal Code provides an example, Polish Penal Code art. 227 (1932). *Id.* at 368, n.73.
6 The Penal Code of Uruguay art. 37 provides: "The judges are authorized to forego punishment of a person whose previous life has been honorable where he commits a homicide motivated by compassion, induced by repeated requests of the victim." *Id.* at 369, n.74.
7 State v. Moore, 25 Iowa 128, 135-36 (1868).
8 State v. Tice, 257 Iowa 84, 130 N.W.2d 678 (1964); People v. Lewis, 375 Ill. 330, 31 N.E.2d 795 (1940), *cert. denied*, 314 U.S. 628 (1941).
9 State v. Ehlers, 98 N.J. L. 236, 241, 119 A. 15, 17 (1922).
10 1 WHARTON'S CRIMINAL LAW AND PROCEDURE § 242, at 523-24 (Anderson ed. 1957).
11 People v. Conley, 49 Cal. Rptr. 815, 822, 411 P.2d 911, 918 (1966).
12 2 Park. Crim. Rep. (N.Y.) 28 (1823).
13 *Id.* at 29.
14 *Id.* at 31.
15 *Id.*
16 Silving, *supra* note 2, at 363.

> fully, that is, with intent to kill . . . and as the result of premeditation and deliberation, thereby implying preconsideration and determination, there is murder in the first degree, no matter what [the] defendant's motive may have been. . . .[17]

Likewise, the common law has never recognized consent of the victim as a defense to criminal homicide.[18] Many countries have a special offense of "homicide by request" which makes any killing done at the urgent request of the victim a less culpable crime than murder,[19] but the common law stands for the proposition that:

> [m]urder is no less murder because the homicide is committed at the desire of the victim. He who kills another upon his desire or command is, in the judgment of the law, as much a murderer as if he had done it merely of his own head.[20]

The common law philosophy that life is inalienable[21] precludes any individual from licensing his own destruction.

Finally, this common law belief in the sacredness of life is so absolute and pervasive that it even protects those who are dying.

> The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—. . . are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment. . . .[22]

As long as the least spark of life remains, it is criminal to extinguish it.[23]

Thus, those special factors which may be said to distinguish euthanasia from more reprehensible forms of killing—a humanitarian motive, possible consent of the victim, the victim's hopeless condition—are irrelevant in the eyes of the law. The common law makes no exception for euthanasia, but jealously guards the life of every individual, however grotesque it may be. One who acts to shorten such a life, for any reason whatsoever, is guilty of murder in the first degree.

A similar liability is imposed on one who aids another in the commission of euthanasia, or who is part of a successful conspiracy to commit euthanasia. The common law holds an accomplice[24] to crime or a conspirator[25] as guilty as the person who actually commits the offense, and subjects them to similar punishment. Thus, a family which decided that a dying relative's suffering should be put to an end, and therefore agreed to persuade medical personnel to perform the act, would be guilty of conspiracy to commit murder should the result be ac-

17 State v. Ehlers, 98 N.J. L. 236, 240, 119 A. 15, 17 (1922).
18 Martin v. Commonwealth, 184 Va. 1009, 37 S.E.2d 43 (1946); Turner v. State, 119 Tenn. 663, 108 S.W. 1139 (1908).
19 See Silving, *supra* note 2, at 378-86.
20 Turner v. State, 119 Tenn. 663, 671, 108 S.W. 1139, 1141 (1908).
21 State v. Moore, 25 Iowa 128, 135-36 (1868).
22 Blackburn v. State, 23 Ohio St. 146, 163 (1872).
23 State v. Mally, 139 Mont. 599, 366 P.2d 868 (1961); State v. BeBee, 113 Utah 398, 195 P.2d 746 (1948); State v. Francis, 152 S.C. 17, 149 S.E. 348 (1929).
24 People v. McArdle, 295 Ill. App. 149, 14 N.E.2d 683 (1938).
25 Pinkerton v. United States, 328 U.S. 640 (1946).

complished. No such case has arisen in this country, and there have been no American prosecutions for aiding an affirmative act of euthanasia, but a Belgian family and physician were tried several years ago as accomplices to the mercy killing of a "thalidomide" baby in Liege.[26]

B. *Aiding and Abetting Suicide*

So strong was the common law concern for life that it even prohibited a person from taking his own life.[27] Suicide was a common law felony, punishable by forfeiture of goods and burial in a public road with a stake through the body;[28] and apparently was considered a form of self-murder, for one who aided another in the commission of suicide was held guilty of murder as an accomplice.[29]

Although the American law never assimilated the severe English punishments for suicide,[30] and successful suicide is no longer punished in any state of the Union,[31] aiding and abetting a suicide remains a criminal offense in most American jurisdictions.[32] Some states still regard it as murder,[33] while others make it a statutory form of manslaughter[34] or an entirely separate offense.[35] Prosecution for aiding and abetting a suicide, however, is rare. In fact, under the old common law system of parties to crime,[36] an accessory to a suicide could not be prosecuted at all. It was a common law rule that conviction of the principal was a condition precedent to prosecution of an accessory, and since the principal was dead and therefore immune to prosecution, the accessory could never be brought to trial.[37] The abolition of such distinctions as principal and accessory[38] has disposed of this curious rule, however, and aiders and abettors

26 In May of 1962, Mme. Suzanne Vandeput gave birth to a "thalidomide" baby in Liege, Belgium. Her mother pleaded with the attending surgeon to kill the infant, but he refused. When the baby was brought home, the family decided the child was better off dead, and a lethal prescription was obtained from the family physician who had originally prescribed the deforming drug. Mme. Vandeput put the lethal dose of sedative into the infant's formula and fed it to the baby. She was tried for murder along with her mother, her sister, her husband and the family physician. All were acquitted after the jury was told of a public referendum which tallied 16,732 votes to 938 votes in favor of acquittal. Gallahue, *Tragedy at Liege,* LOOK, March 12, 1963, at 72. The case is important as one of the few mercy killing prosecutions involving a physician.

27 State v. Ehlers, 98 N.J. L. 236, 241, 119 A. 15, 17 (1922).

28 State v. Campbell, 217 Iowa 848, 251 N.W. 717, 718 (1933).

29 Commonwealth v. Hicks, 118 Ky. 637, 82 S.W. 265 (1904).

30 Burnett v. People, 204 Ill. 208, 222, 68 N.E. 505, 510 (1903).

31 W. LAFAVE & A. SCOTT, JR., CRIMINAL LAW 569 (1972) [hereinafter cited as LAFAVE].

32 *Id.* at 570-71.

33 People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920); Commonwealth v. Hicks, 118 Ky. 637, 82 S.W. 265 (1904). The defendant in the Roberts case mixed paris green, a poison, and placed it near his wife's bedside at her request. He was convicted of murder as an accomplice to her suicide.

34 The N.Y. Penal Law provides an example, N.Y. Penal Law § 125.15 (McKinney 1967).

35 Kan. Stat. Ann. § 21-3406 (1972 Cum. Supp.) provides an example.

36 The common law recognized four categories of criminal participation; principal in the first degree, principal in the second degree, accessory before the fact and accessory after the fact. A principal in the first degree was one who actually performed the criminal act. A principal in the second degree and an accessory before the fact were persons who gave aid or encouragement to the actual offender, the primary distinction being that the principal (second degree) was present at the commission of the offense, while an accessory before the fact was not. An accessory after the fact was one who gave aid after the felony had already been committed. LAFAVE, *supra* note 31, at 495.

37 Commonwealth v. Hicks, 118 Ky. 637, 82 S.W. 265, 266 (1904).

38 *Id.*

now remain liable to prosecution under the several American approaches discussed above.[39]

C. *Euthanasia by Omission*

Where the life of a dying patient is terminated by a positive act, such as suffocation, poisoning, etc., criminal liability is clear; but euthanasia by omission (sometimes referred to as antidysthanasia)[40] remains one of the unsettled areas of the law. The common law recognizes that death can be caused by a failure to act as well as positive action, but it has imposed criminal liability for such deaths only where the person guilty of the omission has a clear duty to act.[41] As the leading American case states the law, this duty must be

> . . . a *legal* duty, and not a mere moral obligation. It must be a duty imposed by law or by contract, and the omission to perform the duty must be the immediate and direct cause of death.[42]

The question of euthanasia by omission has generally been stated in terms of medical situations—whether a doctor who fails to take positive steps to prolong the life of a dying patient is guilty of homicide—and since there has never been a case dealing with this issue,[43] no clear legal answer can be given. This should not, however, preclude an analysis of the problem based on available materials.

As stated above, the law imposes criminal liability for an omission to act only where there is a legal duty to do so; therefore, any discussion of a physician's liability for omission should begin with an examination of duty. If there is no duty, there is no liability.

The relationship between physician and patient is basically contractual,[44] arising from the nature of an offer and acceptance. The patient comes to the doctor seeking his services (an offer of employment), and the doctor is free to accept the patient or not. A doctor is under no obligation to treat all comers.[45] However, once the doctor has undertaken to render treatment, the law imposes a *duty* on him to continue such treatment as long as the case requires, in the absence of an agreement to the contrary.[46] On the basis of this duty, many commentators have concluded that there is a theoretical basis for imposing criminal liability on a physician who fails to take all necessary action to prolong the life of a dying patient.[47] This duty is not absolute, however, and

39 See text accompanying notes 33-35.

40 Antidysthanasia has been defined as the failure to take positive action to prolong the life of an incurable patient. S. SHINDELL, THE LAW IN MEDICAL PRACTICE 118 (1966).

41 *See* Frankel, *Criminal Omissions: A Legal Microcosm,* 11 WAYNE L. REV. 367 (1965); Hughes, *Criminal Omissions,* 67 YALE L. J. 590 (1958); Kirchheimer, *Criminal Omissions,* 55 HARV. L. REV. 615 (1942).

42 People v. Beardsley, 150 Mich. 206, 113 N.W. 1128, 1129 (1907) (emphasis added).

43 Gurney, *Is There a Right to Die?—A Study of the Law of Euthanasia,* 3 CUMBERLAND-SAMFORD L. REV. 235, 248 (1972); Kamisar, *supra* note 2, at 983; Silving, *supra* note 2, at 360.

44 SHINDELL, *supra* note 40, at 16-32.

45 Findlay v. Board of Supervisors, 72 Ariz. 58, 230 P.2d 526 (1951); Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901).

46 Ricks v. Budge, 91 Utah 307, 64 P.2d 208, 211 (1937).

47 "[M]any doctors are guilty of murder today, at least to the extent that they fail to

> [t]he obligation of continuing attention can be terminated by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice so as to enable the patient to secure other medical attention.[48]

A dying patient who is desirous of a swift and painless death may theoretically discharge his physician, thereby terminating the physician's duty and eliminating the underlying basis for criminal liability. Thus, the question of criminal liability arises only where the physician has not been discharged or has not withdrawn with proper notice, and where it is assumed that the physician-patient relationship still continues. The physician may not terminate the relationship by abandoning the patient,[49] and it is in this situation that the possibility of criminal liability most frequently arises.

Most of the cases concerning abandonment have involved patients with nonfatal injuries or illness who would have normally recovered with proper medical attention.[50] It is fairly clear in such situations that a doctor who has undertaken to treat the case and who intentionally withholds necessary treatment is guilty of murder by omission. But research has disclosed no case dealing with the abandonment of a patient whose condition was considered terminal. In such instances, criminal liability of the physician depends upon the scope of the physician's duty to his patient, a scope which has never been clearly defined. The general rule is merely that a physician's duty continues "so long as the case requires,"[51] and should a case involving a terminal patient arise, the courts will have to interpret whether this standard means until death finally occurs; or whether it means until the patient's condition becomes hopeless, whereupon the physician would be free to discontinue life-prolonging measures and allow death to come peacefully. By narrowing the scope of professional duty, the physician could be absolved of criminal liability.

Should such a case arise, several factors indicate that the latter interpretation would be adopted by the courts. First of all, the weight of medical opinion is that a physician commits no legal or moral wrong by such omissions.[52] One doctor has stated that:

> [w]here there appears to be no possible chance of return to any type of conscious awareness, much less any comfortable existence . . . [the] act of omitting tube feedings . . . is not euthanasia in subterfuge; it is good medicine.[53]

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administer every known medical means to prolong life in specific instances." Levisohn, *Voluntary Mercy Deaths,* 8 J. FOR. MED. 57, 68 (1961). *See* Fletcher, *Prolonging Life,* 42 WASH. L. REV. 999, 1006 (1967); Kamisar, *supra* note 2, at 983; B. SHARTEL & M. PLANT, THE LAW OF MEDICAL PRACTICE 371 (1959). *But cf.* Gurney, *supra* note 43, at 247; G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 326 (1957).

48 Ricks v. Budge, 91 Utah 307, 64 P.2d 208, 211-12 (1937).

49 Murray v. United States, 329 F.2d 270, 272 (1964); Vann v. Harden, 187 Va. 555, 47 S.E.2d 314, 319 (1948).

50 *See generally* Annot., 57 A.L.R.2d 432 (1958).

51 *See* note 46 *supra.*

52 3 M. HOUTS, COURTROOM MEDICINE § 1.06, at 1-53 (1972).

53 Williamson, *Prolongation of Life or Prolonging the Act of Dying?* 202 J.A.M.A. 162 (1967).

Such omissions are daily occurrences,[54] and it is a common practice among the profession to order hospital personnel not to resuscitate a terminal patient who suffers a cardiac or respiratory arrest.

Another relevant factor is that major religions in this country are in substantial agreement that extraordinary measures such as artificial respirators, etc., need not be applied in hopeless cases.[55] In 1957, Pope Pius XII told an assembly of physicians that when death becomes inevitable, a physician can abandon further efforts to stave off death "in order to permit the patient, already virtually dead, to pass on in peace."[56] There is a moral obligation to insure only conventional medical treatment, and relatives of a dying patient can lawfully request the doctor to stop artificial techniques, and the doctor may lawfully comply.[57] In such cases, the Pope said, there is no question of euthanasia or mercy killing, "which would never be lawful."[58] More recently, the Bishops of The Netherlands formulated the policy that:

> [T]here is no absolute need to prolong indefinitely a life which has been despaired of, by means of medicines and machines, especially if the life in question is purely vegetal, without signs of human reaction. In the latter case above all, extraordinary means may be omitted and the natural process allowed to take its course.[59]

The distinction being made here is between ordinary and extraordinary treatment. Ordinary treatment has been defined as "all medicines, treatments and operations which offer a reasonable hope of benefit, and which can be obtained and used without excessive expense, pain or other inconvenience.[60] Extraordinary means are considered those which do involve the above factors, or which, if used, would offer no reasonable hope of benefit.[61] Thus, the proposition purports that although physicians have a moral duty to continue ordinary treatment of dying patients (such as relieving pain), there is no moral duty to use extraordinary means to prolong a life which has been despaired of. Lord Justice Coleridge, in speaking of omissions and legal duty, stated: "It is not correct to say that every moral obligation is a legal duty; but every legal duty is founded upon a moral obligation."[62] Thus, whereas use of extraordinary treatment is not considered a moral duty by many religious groups who expressly condemn any form of positive euthanasia, there is some authority for the proposition that it is not a legal duty as well.

A third important consideration is that where the question has been raised in foreign jurisdictions, there apparently has been no finding of liability. For example, a Swedish doctor, after consulting with the patient's family, discon-

54 Wilkes, *When Do We Have the Right to Die?* LIFE, Jan. 14, 1972, at 48.
55 SHINDELL, *supra* note 40, at 120.
56 N.Y. Times, Nov. 25, 1957, at 1, col. 3.
57 *Id.* at 20, col. 5.
58 *Id.*
59 D. MEYERS, THE HUMAN BODY AND THE LAW 140 (1970).
60 N. ST. JOHN-STEVAS, *supra* note 2, at 275.
61 *Id.* at 275-76.
62 Quoted in People v. Beardsley, 150 Mich. 206, 212, 113 N.W. 1128, 1130 (1907).

tinued intravenous nourishment of an elderly patient who had suffered a cerebral hemorrhage and who was lingering needlessly.[63] After the patient's death, the case was reviewed by a panel of two doctors, two lawyers, and a member of the Swedish Parliament; but the panel was unable to decide whether the doctor had committed a crime or was guilty of professional neglect. The local prosecutor charged the doctor with professional neglect, but a court acquitted him on the ground that "continuance of the [intravenous] drip would not have fulfilled either a medical or human purpose."[64] A similar result would apparently be reached in Germany. Although German law holds that deliberate nonfeasance with intent to cause death may be punishable homicide, Helen Silving, an expert in the field, quotes a German authority that " 'the physician's failure to prolong artificially an expiring painful life by applying stimulants, such as camphor injections, is not regarded as homicide' under German law."[65] A German court some years ago found a defendant guilty of manslaughter for failing to rescue her husband from hanging himself, but the court emphasized that the victim was *not* incurably ill.[66]

The opinions of doctors, theologians and foreign jurisdictions are certainly not precedent; but it is likely that such considerations would play an important part in any future decision on the scope of a physician's duty to a dying patient. Should the ordinary/extraordinary test be adopted, most cases of euthanasia by omission would not be within the prohibition of the criminal law.

D. *Time and Definition of Death*

A problem closely related to that of duty is the question, "When does death occur?" Since a living victim is a necessary element of the corpus delicti,[67] a legal determination of when death occurs is important in establishing whether a homicide has been committed, as the following case will illustrate. On June 16, 1963, a man named Potter was admitted to a British hospital after receiving four skull fractures and extensive brain damage in a brawl. Fourteen hours after admission he stopped breathing and was placed on an artificial respirator. The following day, with the consent of Potter's wife and an attending coroner, doctors removed one of his kidneys for use in a transplant operation. Following this procedure, the respirator was stopped and an absence of spontaneous breathing and respiration was noted.[68] Under these circumstances, were the doctors guilty of murder? Disregarding the issue of duty for the moment, the answer depends on the *legal* definition of death.

Legal death has traditionally been defined as

> [t]he cessation of life . . . defined by physicians as a total stoppage of the

63 HOUTS, *supra* note 52 § 1.06, at 1-55.
64 *Id.*
65 Silving, *supra* note 2, at 359.
66 *Id.* at 359-60, 373 n.94.
67 1 WHARTON'S CRIMINAL LAW AND PROCEDURE § 189, at 435 (Anderson ed. 1957).
68 HOUTS, *supra* note 52 § 1.06, at 1-58—1-59; Halley & Harvey, *Medical vs. Legal Definitions of Death,* 204 J.A.M.A. 423 (1968).

> circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.[69]

According to the traditional definition, then, Potter was still alive until the respirator was stopped, and the doctors would be liable for his death. It has been pointed out, however, that such a definition is impractical in light of modern artificial means of continuing heartbeat and respiration almost indefinitely:

> From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes; so the obvious criterion of no heart beat as synonymous with death was sufficiently accurate. In those times the heart was considered to be the central organ of the body; it is not surprising that its failure marked the onset of death. *This is no longer valid when modern resuscitative and supportive measures are used.* These improved activities can now restore "life" as judged by the ancient standards of persistent respiration and continuing heart beat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain damage.[70]

In place of the traditional definition, doctors have suggested the concept of "functional" death; *i.e.*, when the brain no longer functions and has no possibility of functioning again, the patient is for all practical purposes dead notwithstanding the fact that heartbeat and respiration may be continued by mechanical means.[71] This absence of functional brain activity (or brain death) is determined by an isoelectric (flat wave) pattern on an electroencephalograph over a continued period of time, then death is pronounced and artificial means of support may be discontinued without fear of liability. Homicide cannot be committed on a person who is dead.[72] If this standard had been applied in the *Potter* case above and Potter pronounced dead when he first stopped breathing, the doctors would incur no criminal liability for the subsequent removal of the kidney and the termination of artificial resuscitation. In fact, a coroner's jury did rule that Potter's death occurred on June 16, when spontaneous breathing ceased, apparently because "medical research had been advanced."[73]

American courts, however, have been reluctant to accept the brain death criteria. In *Smith v. Smith*,[74] counsel for the petitioner offered to prove that a man who was killed instantly in an automobile accident, and his wife who lingered in a comatose state for seventeen days, had actually died simultaneously:

> "[A]s a matter of modern medical science, your petitioner alleges and states, and will offer the Court competent proof that the said Hugh Smith, deceased, and the said Lucy Coleman Smith, deceased, lost their power to will at the same instant, and that their demise as earthly human beings oc-

69 Schmitt v. Pierce, 344 S.W.2d 120, 133 (Mo. 1961); Smith v. Smith, 229 Ark. 579, 586, 317 S.W.2d 275, 279 (1958); Thomas v. Anderson, 96 Cal. App. 2d 371, 376, 215 P.2d 478, 481-82 (1950).

70 *A Definition of Irreversible Coma,* 205 J.A.M.A. 337, 339 (1968) (emphasis added).

71 *Id.* at 337; Letter from Loren F. Taylor to the *Journal of the American Medical Association* in 215 J.A.M.A. 296 (1971).

72 Treatise cited note 67 *supra.*

73 Comment, *Liability and the Heart Transplant,* 6 HOUSTON L. REV. 85, 90 (1968).

74 299 Ark. 579, 317 S.W.2d 275 (1958).

> curred at the same time in said automobile accident, neither of them ever regaining any consciousness whatsoever."[75]

The court, in rejecting this argument, cited the traditional legal definition and stated:

> Admittedly, this condition did not exist, and as a matter of fact, it would be too much of a strain on credulity for us to believe any evidence offered to the effect that Mrs. Smith was dead, scientifically or otherwise, unless the conditions set out in the definition existed.[76]

The court also took judicial notice that "one breathing, though unconscious, is not dead."[77]

The argument of counsel in the *Smith* case was a poor attempt, at best, but a more significant argument was presented in *Douglas v. Southwestern Life Insurance Company.*[78] The *Douglas* case involved an attempt to collect double indemnity on a life insurance policy which allowed such benefits if death resulted from accidental means within ninety days of injury. The deceased had been seriously injured in an automobile accident on June 4, 1961, and because of what the court termed "extraordinary medical measures" his life had been prolonged until October 2, which was 120 days after the accident. The court found that had such extraordinary measures not been taken, the deceased would probably have died within the ninety-day period, but it held that death occurred on October 2 and denied recovery.

In the absence of a satisfactory judicial response, one state has enacted a unique statutory definition of death.[79] For purposes of the statute, death occurs when there is an absence of spontaneous respiratory and cardiac function, and attempts at resuscitation are considered hopeless; *or,* when there is an absence of spontaneous *brain function* and it appears that further supportive maintenance will be useless. Since the statute expressly applies to criminal cases, physicians in

75 *Id.* at 277.
76 *Id.* at 279.
77 *Id.* at 281.
78 374 S.W.2d 788 (Tex. Civ. App. 1964).
79 Kan. Stat. Ann. § 77-202 (Cum. Supp. 1972).

> Definition of death. A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or
>
> A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory function are terminated and before any vital organ is removed for purpose of transplantation.
>
> These alternative definitions of death are to be utilized for all purposes in this state, including the trials of civil and criminal cases, any laws to the contrary notwithstanding.

this jurisdiction now have a fairly clear standard for determining when extraordinary means may be discontinued in the absence of a judicial determination on the scope of duty.

E. *The Law in Practice*

Despite evidence that euthanasia is widely practiced, at least by omission,[80] and the broad liability imposed by the common law, there have been few prosecutions for mercy killing in this country. As long ago as 1916, a leading treatise of the period stated:

> Publicists have considered somewhat the question whether life may not be taken, with the consent of its possessor, to relieve from suffering or other greater calamity; but the courts have had to concern themselves very little with such considerations. In the practical operation of the law this question will rarely if ever arise. When the act which immediately produces death is meritorious in character, prosecuting officers will hardly make it the foundation of a criminal prosecution.[81]

Hindsight has shown that even where prosecution is undertaken, juries are reluctant to convict or judges are reluctant to impose harsh sentences. A survey of twelve American cases involving positive acts of euthanasia reveals one failure to indict, seven acquittals, three convictions for an offense less than murder, and only one conviction for murder itself.[82] The single murder conviction in-

80 Arthur A. Levisohn sent a questionnaire to 250 Chicago internists and surgeons, and of the 156 who replied, 61% answered the question, "In your opinion do physicians actually practice euthanasia in instances of incurable adult sufferers?" in the affirmative. One doctor added, "Is letting a patient die for lack of a life sustaining hormone or antibiotic, euthanasia?" Levisohn, *supra* note 47, at 68.

81 13 R.C.L. 734 (1916).

82. A. Harry Johnson was arrested for asphyxiating his cancer-stricken wife, N.Y. Times, Oct. 2, 1938, at 1, col. 3, but when the grand jury received testimony from a psychiatrist that Johnson was "temporarily insane" at the time of the act it refused to indict. N.Y. Times, Oct. 19, 1938, at 46, col. 1.

B. Louis Greenfield chloroformed his seventeen year old imbecile son. N.Y. Times, May 9, 1939, at 48, col. 1. The prosecutor admitted he was reluctant to prosecute, and Greenfield was acquitted of first-degree manslaughter. *"Better Off Dead,"* TIME, Jan. 23, 1939, at 24.

C. After reading about the Greenfield case, N.Y. Times, Oct. 14, 1939, at 21, col. 2, Louis Repouille chloroformed his thirteen year old mongoloid and blind son. N.Y. Times, Oct. 13, 1939, at 25, col. 7. He was indicted for first-degree manslaughter, but was convicted of second-degree manslaughter with a recommendation of clemency. N.Y. Times, Dec. 10, 1941, at 27, col. 7. His five to ten year sentence was suspended. N.Y. Times, Dec. 25, 1941, at 44, col. 1. *See also* Repouille v. United States, 165 F.2d 152 (2d Cir. 1947).

D. John Noxon, 1943. See discussion of this case in the text *infra.*

E. Dr. Hermann Sander, 1950. See discussion of this case in the text *infra.*

F. Carol Paight, a twenty-one year old college student, shot her father to death in his hospital room shortly after it was discovered that he had terminal cancer. She was acquitted on the ground of temporary insanity. *For Love or Pity,* TIME, Feb. 6, 1950, at 15; N.Y. Times, Feb. 8, 1950, at 1, col. 2.

G. Harold Mohr was charged with killing his blind cancer-stricken brother. He was convicted of voluntary manslaughter, with a recommendation of clemency, and was sentenced to three to six years' imprisonment plus a $500 fine. N.Y. Times, April 11, 1950, at 20, col. 5. There was testimony that the defendant had been drinking, and two brothers testified against him. N.Y. Times, April 4, 1950, at 60, col. 4; *id.*, April 8, 1950, at 26, col. 1.

H. Eugene Braunsdorf was worried about his health and concerned about the future of his twenty-nine-year-old spastic daughter should he die. He took her out of the private sanitarium where she was being cared for, shot her to death, and attempted suicide but failed. He

volved an attorney, John Noxon, who was charged with electrocuting his six-month-old mongoloid son by wrapping a lamp cord around his neck.[83] He was convicted of first-degree murder and sentenced to death,[84] but his sentence was commuted to life[85] and later reduced to six years to make him eligible for parole.[86] He was paroled shortly thereafter.[87]

The only American case to involve a physician was that of *State v. Sander*.[88] Dr. Hermann Sander was accused of injecting 40 cc. of air into the vein of a cancer patient, Mrs. Abbie Borroto, thereby causing her death.[89] The doctor never denied his actions and had even dictated the following notation into the hospital record: "Patient was given 10 cc. of air intravenously repeated four times. Expired within ten minutes after this was started."[90] It was reported that when the county medical referee had asked the doctor if he knew he had broken the law, Sander replied that he had broken the law before and nothing had happened. When the referee told him it was murder, Dr. Sander allegedly replied that the law should be changed.[91] There was evidence at the trial, however, that the patient might already have been dead when Dr. Sander gave her the injections,[92] and expert testimony that 40 cc. of air would not be sufficient to be a cause of death.[93] The doctor was acquitted. It is interesting to note that before the trial, more than 90 per cent of the doctor's townspeople were reported to have signed a petition in support of the physician.[94]

Perhaps the most unusual mercy killing case was that of Otto Werner, 69, of Chicago.[95] Werner was charged with murder for suffocating his crippled and bedridden wife upon learning that they were being sent to a nursing home. At his bench trial, the defendant entered a plea of guilty to voluntary manslaughter

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was acquitted on the ground of temporary insanity. *Murder or Mercy?* TIME, June 5, 1950, at 20. N.Y. Times, May 23, 1950, at 25, col. 4.

I. Herman Nagle, a retired New York policeman, admitted that he shot to death his twenty-eight-year-old daughter who suffered from cerebral palsy. N.Y. Times, Sept. 7, 1953, at 31, col. 1. He was charged with first-degree murder, but was acquitted on the ground of temporary insanity after twenty minutes of jury deliberation. N.Y. Times, Dec. 24, 1953, at 20, col. 7.

J. Otto Werner, 1958. See discussion of this case in the text *infra*.

K. William Reinecke, 84, was charged with strangling his seventy-four-year-old wife who suffered from terminal cancer. He was placed on probation after the state's attorney said society needed no further protection from the man. Chicago Daily News, Aug. 10, 1967, at 1.

L. Robert Waskin, a twenty-three-year-old college student, shot to death his mother who was suffering from leukemia and who had begged him to kill her. Chicago Daily News, Aug. 10, 1967. He was acquitted on the ground of insanity, found no longer insane, and released. Chicago Tribune, Jan. 25, 1969, at 1, col. 8.

83 N.Y. Times, Sept. 28, 1943, at 27, col. 2; *id.*, Sept. 29, 1943, at 23, col. 7; *id.*, Oct. 29, 1943, at 27, col. 7. *See also* Commonwealth v. Noxon, 319 Mass. 495, 66 N.E.2d 814 (1946).

84 N.Y. Times, July 7, 1944, at 30, col. 2.

85 *Id.*, Aug. 8, 1946, at 42, col. 4.

86 *Id.*, Dec. 30, 1948, at 13, col. 5.

87 *Id.*, Jan. 4, 1949, at 16, col. 3.

88 New Hampshire, 1950.

89 N.Y. Times, Feb. 24, 1950, at 1, col. 6; 48 MICH. L. REV. 1197 (1950).

90 *"Similar to Murder,"* TIME, March 6, 1950, at 20.

91 *Id.*

92 *Id.*

93 N.Y. Times, March 8, 1950, at 1, col. 6.

94 *Id.*, Jan. 2, 1950, at 25, col. 2.

95 People v. Werner, Crim. No. 58-3636 (Cook Co. Ct., Ill. 1958). A portion of the transcript of this case is presented in Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178, 184-87 (1966).

and his plea was accepted. Upon receiving testimony of the defendant's loving and devoted care for his wife, however, the judge suggested that the defendant withdraw his plea of guilty, entered a plea of not guilty, and acquitted him saying.

> Courts don't condone mercy killings and I do not, but . . . we certainly have no reason to be concerned about his committing any comparable crimes or any further crimes. . . .
>
> I am inclined to think that a jury, if he were tried with a jury, and testimony was brought out of his devotion and care to his wife in her incurable illness and of her constant pain and suffering, the jury would not be inclined to return a verdict of guilty.[96]

This latter case illustrates the fact that although motive has never been a recognized defense at common law, it has crept in through the actions of judges and juries. It has become a *de facto* mitigation,[97] and this is by no means a purely American phenomenon. In a recent British case, James Price confessed to having drowned his six-year-old son, whom he described as a "living cabbage," in a secluded English river.[98] The judge placed him on probation after 600 of Price's neighbors signed a petition asking for clemency.[99]

Where mercy killings by omission are concerned, there have been no cases at all.[100] Several reasons may account for this. First of all, the law is unclear in this area.[101] Secondly, such mercy killings are frequently consensual—the patient's doctor and family will reach a consensus that "We have done all we can," and that the patient should be spared a prolonged and pitiful death.[102] In such situations there will rarely be a complaining witness to institute prosecution. Thirdly, where the event is not consensual, it is likely to take place in the privacy of a hospital room, out of public view, thus presenting difficult problems of proof and causation. Finally, in any type of euthanasia case, public sentiment is generally in sympathy with the mercy killer, not against him.

F. *Alternatives*

The common law has often been criticized for this disparity between the law in theory and the law in practice regarding euthanasia.[103] Several alternatives have been suggested to make the law on the books more consistent with the law in the courtroom, and these proposals generally take one of two approaches—either legalizing euthanasia for the victim, or mitigating the penalty for the actor.[104]

96 *Id.* at 186. For criticism of this case see 34 NOTRE DAME LAWYER 460 (1959).
97 Kalven, *A Special Corner of Civil Liberties: A Legal View I,* 31 N.Y.U.L. REV. 1223, 1235 (1956).
98 N.Y. Times, Dec. 26, 1971, at 47, col. 7.
99 *Id.*
100 Authorities cited note 43 *supra.*
101 *See* text accompanying notes 40-66 *supra.*
102 *See* A. VERWOERDT, COMMUNICATION WITH THE FATALLY ILL 160-67 (1966).
103 *See* Kutner, *Due Process of Euthanasia: The Living Will, a Proposal,* 44 IND. L. J. 539, 549 (1969); Sanders, *Euthanasia: None Dare Call It Murder,* 60 J. CRIM. L.C. & P.S. 351, 357 (1969); Silving, *supra* note 2, at 352-54; G. WILLIAMS, *supra* note 47, at 326-28.
104 Kalven, *supra* note 97, at 1235.

The first approach has generally taken the form of legislation which would give a terminal patient the right to request euthanasia, and grant immunity to doctors acting in accordance with the statute.[105] The second approach—mitigating the penalty for the actor—involves several different proposals. The most common of these is that the common law should expressly recognize motive as a mitigating factor, at least where euthanasia is concerned.[106] This would have the effect of making euthanasia a lesser offense than murder. Silving suggests that a statutory provision taking account of both motive and consent of the victim would provide the most uniform and appropriate results.[107] In essence, this second class of proposals calls on the common law to adopt several characteristics of the European codes—motive as a mitigating factor, homicide by request, etc. One commentator has stated that it would be unrealistic to "expect the entire criminal law to change to accommodate euthanasia,"[108] but that it would be pragmatic to make euthanasia an exception to the strict common law of homicide. To date, however, such proposals have met with little success, and those who would favor more lenient treatment of euthanasia are turning towards constitutional law as a more rapid vehicle of change.

III. Tort Law

A. *The Absence of a Theory of Recovery for Euthanasia*

The tort aspect of euthanasia, whether voluntary or involuntary, has not been examined by the legal writers[109] but has been dwarfed by the more sensational and conspicuous criminal and legislative facets of "mercy-killing." A tort action typically has rather narrow implications to the public at large as compared to the broad impact of a commercial or constitutional decision. This peculiarity can be essentially attributed to the compensatory purpose of a tort action.[110] Functionally, this has the less obvious effect of diminishing the precedent value of the decision.[111] This results because the circumstances between the immediate parties governs the court's determination of the suit to a greater extent than the form of the parties' interaction. The court views the different combination of circumstances comprising the act as giving rise to various theories of recovery rather than one theory. An example of this is murder. Rather than one theory encompassing the act of killing, a homicide could give rise to recovery for assault, battery and false imprisonment depending on the circumstances. There are many types of individual interests, and they may be invaded differently on each occurrence of the same type of act.[112] Consequently, the precedent value of finding express tort liability for euthanasia would be minimal as compared to the criminal

105 *See* text accompanying notes 423-472 *infra.*
106 Note, *The Right to Die,* 7 HOUSTON L. REV. 654, 661 (1970); Sanders, *supra* note 103, at 357; Note, *Legal Aspects of Euthanasia,* 36 ALBANY L. REV. 674, 676-77 (1972).
107 Silving, *supra* note 2, at 363, 388-89.
108 Note, *Legal Aspects of Euthanasia, supra* note 106, at 677.
109 *See Medicolegal Brief. The Right to Die.* 19 REV. ALLERG. 523 (1965).
110 W. PROSSER, LAW OF TORTS 7 (4th ed. 1971).
111 *See, e.g.,* Summers v. Tice, 33 Cal.2d 80, 199 P.2d 1 (1948).
112 W. PROSSER, *supra* note 110, at 6.

law's determination that euthanasia is murder.[113] Any decision imposing tort liability for euthanasia must be a composite of various theories of recovery such as battery, assault or intentional infliction of mental distress. There can be no one theory of recovery encompassing all euthanasia actions. This is contrary to criminal law which equates euthanasia with murder.

Besides the lack of precedent value to attract the legal writers, such a cause of action does not touch the imagination and empathy as does a criminal action for "mercy-killing." A good example of this is the case of Robert Waskin.[114] In that case, the populace could sympathize with the emotionally distraught student who acquiesced in the request of his dying, leukemia-stricken mother to kill her. The literature would immediately seize upon such an episode because of its appeal. Such pathos can scarcely be expected to be evoked by a malpractice or battery action having as its objective compensation rather than accusation.

Research has not bared any tort actions arising from an alleged act of euthanasia. However, it is quite logical to speculate that not infrequently a cause of action which could have alleged euthanasia has been filed under a more euphemistically acceptable theory such as child beating, negligence or nonfeasance.[115] The public's repugnance for placing blame for the administration of euthanasia[116] could only hinder the chances of a successful recovery where an act of "mercy-killing" is alleged. Further, since such an action would usually implicate a physician, it would needlessly pique the medical community because the concept of euthanasia conflicts with the Hippocratic oath.[117] Finally, due to the special laws regarding a physician's integrity[118] such an allegation would serve only to impede a plaintiff's case by imposing a heavier burden of proof. Strategically, excluding this controversial and emotion-laden issue would be the more expedient approach and avoid obscuring the pertinent issues.

Whether a tort action expressly alleges euthanasia or not, the physician, spouse or friend of the decedent is potentially liable. This liability looms greater as medical science increases longevity without retarding bodily deterioration. Consequently, death becomes more protracted[119] and requests for euthanasia will be more prevalent as individuals become more conscious of the quality of their existence rather than viewing existence in absolute terms.[120] This liability which can materialize at any time in a survival or wrongful death action[121] would remain as a spectre to haunt the perpetrator. Such liability will exist even if he

113 Silving, *supra* note 2.
114 Note 82L, *supra.*
115 This should not be interpreted as an indictment of any particular class or group. It is a statement of the realities of euthanasia created by the many fact situations within the definition of "mercy-killing."
116 *See generally,* Gurney, *supra* note 43, at 250.
117 Kamisar, *supra* note 2 at 984 n.42.
118 Schejedahl, *Voluntary Euthanasia,* 53 MINN. MED. 693 (1970).
119 D. MEYERS, *supra* note 59, at 159.
120 J. FLETCHER, MORALS AND MEDICINE 187 (1955).
121 *See generally* S. SPEISER, RECOVERY FOR WRONGFUL DEATH (1966). A discussion of the different state approaches to wrongful death and survival actions and their application to euthanasia is pertinent but goes beyond the intent of this survey. Especially relevant in this aspect of tort actions are those states that go beyond Lord Campbell's restriction of recovery to pecuniary loss. They authorize recovery of nonpecuniary damages such as the sentimental value of companionship and affection.

acts with humanitarian motives[122] and with the voluntary consent of the victim.[123]

B. *An Approach to the Tort Aspects of Euthanasia*

In the absence of case law and legal literature to guide an examination of the tort implications of euthanasia, it becomes necessary to construct a perspective. Whether euthanasia is administrated with or without consent, its administration is effectuated either by a withdrawal of a life-supporting agent or by the employment of an active agent. Thus, euthanasia by its definition requires a relationship of actor-victim for implementation. Ordinarily, tort principles impute to the actor a standard of care based on ordinary knowledge.[124] However, the law attributes the possession of special knowledge to one who holds himself out as possessing such knowledge or undertakes a course of conduct which the victim would reasonably recognize as requiring such knowledge.[125] Therefore, if an individual with no medical expertise administers euthanasia with the consent of the victim who recognizes the administer's lack of medical knowledge, the administrator could be held to a standard of ordinary care. This result is totally unacceptable. The decision to administer euthanasia is impregnated with medical considerations not only as to the method of its administration but also as to when it should be administered. Although the law may regard the layman as only possessing ordinary knowledge, his decision to administer euthanasia on another should be construed as conclusively manifesting that he has formed a judgment according to standards promulgated by and for the medical community. To avoid or mitigate liability for euthanasia, the perpetrator should be held to medical standards which demand that he administer only to a patient who has the capacity to consent and has given an informed consent to the act. The administrator of euthanasia, whether or not a physician, should be held to the same standards as a physician performing medical treatment.[126] An examination of the criminal cases dealing with euthanasia exposes a recurring fact pattern which places the defendant in a role in which the law should impose a physician's duty or at least a duty which is similarly defined. An individual who administers euthanasia to a mongoloid child he considers incapable of leading a "human" existence[127] or an individual who acquiesces in the request of a terminal leukemia victim to kill her[128] is making a medical determination.

From a public policy standpoint, the administrator of euthanasia should be held to a standard requiring special knowledge. The administration of voluntary euthanasia deprives the decedent's estate of a prospective economic benefit from further earnings and accumulation of wealth unless the decedent was terminably

122 *See* Silving, *supra* note 2, at 362.
123 W. PROSSER, *supra* note 110, at 107.
124 RESTATEMENT (SECOND) OF TORTS § 289 (1965).
125 *Id.* § 290, comment f.
126 *See generally* McCord, *The Care Required of Medical Practitioners,* 12 VAND. L. REV. 549 (1959).
127 *See e.g.,* note 82B, *supra.*
128 *See e.g.,* note 82L, *supra.*

incurable.[129] When the victim's illness is terminal, the act of "mercy-killing" will not usually cause the loss of any economic benefit to the estate which would have accrued had the victim died from natural causes.[130] However, if treatments exist which could restore a leukemia-stricken victim to good health and allow him to function in society, but such treatments were unknown outside the medical community,[131] the uninformed consent of the victim or his guardian to euthanasia would deprive the estate of prospective economic benefits. Therefore, in fairness to the decedent and his estate, the perpetrator should act only with an informed consent of the victim or his guardian sufficient to satisfy the standards imposed on a physician who renders medical treatment.

It is for the above reasons that the perpetrator should be deemed to possess the special knowledge demanded of a medical practitioner. Imposing such a standard of care is a policy decision directed by the serious impact of euthanasia on the decedent and his estate. Requiring only ordinary care of the perpetrator does not adequately safeguard the victim from a medically unsound decision to perform a "mercy-killing." The harshness of imputing medical knowledge to a layman is offset by balancing it against the necessity for protecting the victim and his estate from the irresponsible administration of euthanasia.

At this point, a distinction should be made between voluntary and involuntary euthanasia. Imposing tort liability in a wrongful death or survival action for voluntary euthanasia is complicated by the presence of the decedent's consent. As will be later discussed, consent avoids or mitigates liability in some jurisdictions for torts which are also criminal acts. However, consent is not a factor in imposing liability for involuntary euthanasia which is the administration of "mercy-killing" without the consent of the victim or his guardian. Involuntary euthanasia is a battery[132] which imposes liability regardless of whether the perpetrator is held to possess ordinary or special knowledge. Therefore, the discussion of the tort aspect of euthanasia will be principally directed to voluntary euthanasia.

C. *Consent*

In the law of Torts, consent operates to avoid or negate civil liability.[133] It does not act as a privilege. In a case of euthanasia such an avoidance of liability should be dependent upon the mental capacity of the decedent as well as the presence or absence of an informed consent. Additionally, when an issue such as euthanasia is involved which constitutes a criminal act, consent must comply

129 *See* Note, *Torts: Release by Decedent as Bar to Wrongful Death Action,* 16 OKLA. L. REV. (1963); Note *Wrongful Death—Intra-Family Actions—Child Liable for Death of Parent,* 48 IOWA L. REV. 748 (1963). Particular emphasis should be placed on the law's retreat from family immunity and the validity of consent forms in order to appreciate the broad basis of liability for euthanasia.

130 Attention should be focused on the fact that most insurance policies contain an exception covering death advanced intentionally irrespective of the incurable, terminal status of the insured.

131 *See generally* Kamisar, *supra* note 2, at 993.

132 RESTATEMENT (SECOND) OF TORTS § 18 (1965).

133 W. PROSSER, *supra* note 110, at 101.

with the conflicting jurisdictional treatment of *volenti non fit injuria*.[134]

As previously discussed, since case law has not developed the tort implications of euthanasia, the capacity to consent to "mercy-killing" is the capacity necessary to permit a battery on oneself.[135] Such a standard could excuse one who administers euthanasia requested by an imbecile. This abhorrent result could be effected by pleading that his incapacity to consent was not known to the perpetrator.[136] The more reasonable approach would be to analogize the capacity for consent to euthanasia to the capacity required for consent to a medical operation.[137] Such a standard would avoid the consent of one not having the requisite mental capacity.[138] This approach is dictated not only by the medical implication of "mercy-killing" but also by the need to protect the victim and his estate from irresponsible acts of an administrator of euthanasia.

An adult is presumed to be capable of consenting or withholding his consent to an operation.[139] This presumption may be rebutted by evidence of mental confusion or incapacity which is artificially, organically or psychologically induced.[140] If the patient does not have the capacity to consent, such required permission must be obtained from the spouse, next of kin, authorized guardian or conservator.[141]

A related problem is the limits of one's capacity to refuse medical treatment. A consent to medical therapy may be voided not only by the patient's mental incompetence to consent but also by the law's prohibition of the particular therapy used. Case law has clouded any clear separation of permissible and prohibited treatments. However, writers frequently speak of the validity of one's consent to refuse medical treatments in terms of whether the means of sustaining life is classed as ordinary or extraordinary.[142] The perimeter of ordinary means of treatment which one cannot refuse is a shifting one which is dependent on various factors including present medical knowledge and the expense of the proposed treatments.[143] This elusive standard has been further complicated by conflicting decisions regarding the patient's capacity to refuse ordinary treatments necessary to sustain life.[144] Present case law would appear to sustain an individual's right to refuse only extraordinary means.[145] However, the recent trend of decisions recognizes the individual's capacity to refuse ordinary treatments such as a blood transfusion.[146] With regard to the capacity of a representative to refuse to consent to treatment for the patient, decisions permit a guardian to refuse extraordinary

134 Note, *Consent as Affecting Civil Liability for Breaches of the Peace*, 24 COLUM. L. REV. 819, 821 (1924).
135 W. PROSSER, *supra* note 110, 101.
136 *Cf.* Hollerud v. Malamis, 20 Mich. App. 748, 174 N.W.2d 629 (1969).
137 *See generally*, R. MORRIS AND A. MORITZ, DOCTOR AND PATIENT AND THE LAW 147 (5th ed. 1971).
138 *Id.* at 148.
139 J. WALTZ AND F. INBAU, MEDICAL JURISPRUDENCE 169 (1971).
140 *See, e.g.*, Wheeler v. Barker, 92 Cal. App. 2d 776, 208 P.2d 68 (1949).
141 R. MORRIS AND A. MORITZ, *supra* note 137, at 148.
142 N. ST. JOHN-STEVAS, *supra* note 2, at 52.
143 *Id.*
144 In Re Osborne, 294 A.2d 372 (D.C. App. 1972).
145 *See, e.g.*, John F. Kennedy Memorial Hospital v. Heston, 58 N.J. 576, 279 A.2d 670 (1971).
146 Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).

means of sustaining the life of one incompetent to consent. It is highly doubtful, however, that those few courts which have recognized the individual's capacity to refuse ordinary treatments would also impute this capacity to a guardian or spouse. The cases permitting the refusal of ordinary means of sustaining life have only involved conscious, competent individuals. This right of refusal is inextricably related to any discussion of euthanasia since "mercy-killing" will be most frequently effectuated by a withdrawal of a life-supporting agent.

Generally, a minor does not have the capacity to consent to an operation.[147] There are, however, a few decisions holding that a mature minor may consent if the treatment is simple as in the case of a smallpox vaccination.[148] Usually, however, the guardian, parent or a person *in loco parentis* must consent and it has been suggested that if the child is over thirteen years old, his consent should also be obtained.[149] Similar to the situation involving an unconscious or incompetent adult, an extraordinary method of preserving the minor's life could be refused but only by one authorized to consent for the minor.[150] This most often occurs in the situation of a comatose child with irreparable brain damage. However, it is unlikely that any set of circumstances could be so tailored to comply with those decisions upholding an adult's refusal of ordinary treatment.[151] Such a consent by the guardian would be void and subject the guardian and the administrator of the "mercy-killing" to liability. Even in the recently proposed euthanasia legislation, only one bill has advocated euthanasia of minors. Even this proposal was restricted to the refusal of artificial or extraordinary means of sustaining life.[152]

Implicit in a study of capacity to consent is the problem of interpreting manifestations of consent. Typically, the search for the existence of consent, whether actual or apparent, leads one beyond an either/or investigation and into the task of formulating actual or apparent intention from the individual's words or conduct.[153] Custom and usage would be the guidelines for determining the existence and the extent of consent.[154] Under less emotional circumstances than those surrounding euthanasia, the reasonable man standard, to which the defendant would be held in interpreting the victim's consent, would be rather elastic. The extent of this broad interpretation under normal conditions is demonstrated by decisions construing silence as consent.[155] However, one suspects that a court confronted by consequences as extreme as those involved in euthanasia would not readily entertain a theory of implied or apparent consent. The reasonable supposition is that for a defendant to avoid or mitigate liability, it would be incumbent upon him to adduce evidence of the decedent's express con-

147 *See* J. WALTZ AND F. INBAU, *supra* note 139, at 170.
148 *Accord,* Lacey v. Laird, 166 Ohio St. 12, 139 N.E.2d 25 (1956).
149 R. MORRIS AND A. MORITZ, *supra* note 137, at 148.
150 *Cf.* In Re Frank, 41 Wash. 2d 294, 248 P.2d 553 (1952); *Contra* In Re Vasko, 238 App. Div. 128, 263 N.Y.S. 552 (1933).
151 All cases have concerned adults. In addition, there is the argument of a compelling state interest in the welfare of minors.
152 S.B. 670, Wis. Legislature (1971).
153 *See, e.g.,* O'Brian v. Cunard S.S. Co., Ltd., 154 Mass. 272, 28 N.E. 266 (1891).
154 *See* W. PROSSER, *supra* note 110, at 102.
155 *Cf.* Thibault v. Lalumiere, 318 Mass. 72, 60 N.E.2d 349 (1945).

sent.[156] In *Mohr v. Williams*,[157] the court rejected the argument of implied consent to an operation on the patient's ears. Throughout the opinion the court stressed the lack of express consent while rejecting the conclusion that the circumstances implied consent. Again, analogizing to the consent necessary for medical treatment, one can expect circumspection by a court in finding that a euthanasia victim has consented.

Finally, in view of the ad hoc judicial treatment given the few criminal actions arising from euthanasia, a defendant's liability may rest on which party most craftily exploits the emotion-laden circumstances existing at the time of the act or the omission.[158] This would appear true nothwithstanding a demonstration of express consent,[159] or a failure to establish consent.[160] Another consideration is that the court might be more acquiescent to a plaintiff's claim that mistake, duress or fraud affected the consent of the decedent or his guardian. This would seem to be a valid assumption if a selfish motive such as a desire to avoid the financial burden of the victim's continued treatment could be traced to the defendant's actions.[161] This approach could be used by a court that has reservations about imposing criminal sanctions for euthanasia but desires to balance the equities of a particular case.

D. *Informed Consent*

Analogizing again to the case law treatment of medical therapy, the consent required for the administration of euthanasia should be an "informed consent."[162] Since "mercy-killing" will usually occur in a physician-patient relationship, the perpetrator of euthanasia should bear the burden of informing the victim of the medical risks and alternatives to euthanasia. Arguably, this would be so notwithstanding the absence of medical knowledge on the part of the perpetrator. The law should not permit one to avoid or mitigate liability by acquiescing to the victim's uninformed request for an act which is essentially medical in nature. This reasoning would appear imperative since the perpetrator's decision to follow the victim's request for euthanasia is, at least constructively, a medical determination.

Basically, informed consent requires a disclosure of information and the gaining of consent.[163] This entails the disclosure of the collateral risks to alternative treatments available and the commencement of treatment only after gaining consent to the risks of the proposed treatment. The substance of liability is that the victim's request for euthanasia, whether or not suggested by the perpetrator, would impose on the perpetrator the duty of presenting viable alter-

156 C. POLSON, THE ESSENTIALS OF FORENSIC MEDICINE 538 (2nd ed. 1965).
157 95 Minn. 261, 104 N.W. 12 (1905).
158 *See e.g., Van Put* case discussed in LOOK, Mar. 12, 1963, at 72-78.
159 Note 82L, *supra.*
160 Note 82B, *supra.*
161 A prevalent argument against involuntary and, to some extent, voluntary euthanasia is that "mercy-killing" would serve selfish expedient aims. Those desiring to avoid the financial burden of a prolonged sickness of a family member might favor its use.
162 *See generally* 60 COLUM. L. REV. 1193 (1960). *See also* Plante, *An Analysis of "Informed-Consent,"* 36 FORD. L. REV. 639 (1968).
163 J. WALTZ AND INBAU, *supra* note 139, at 156.

natives to "mercy-killing" with sufficient disclosure of attendant risks. The sufficiency of the disclosure would depend on the standards of the medical community as attested to by expert witnesses.

Notwithstanding the victim's consent the perpetrator would be conclusively presumed to have proposed euthanasia to the victim and he would be liable if the proposal was medically unsound. In other words, the perpetrator's liability would be dependent on whether a physician would be liable for malpractice for proposing euthanasia under similar circumstances. Again, this approach is necessitated by the suggestion that the decision to administer euthanasia is basically a medical determination and that the perpetrator should be held to a standard of care which reflects the status he has usurped by his act.

Liability for failure to disclose would be imposed if the perpetrator failed to disclose risks of alternative treatment. The extent of the disclosure should encompass those risks which were known to him or which would have been known to a reasonably trained physician.

> The duty to know of a risk has two branches: the duty to learn of risks known to others in the profession, and the duty to investigate to discover whether there are risks unknown to others in the profession.[164]

With respect to the nature of alternative treatment, *Bang v. Charles T. Miller Hospital*[165] suggests that informed consent not only involves disclosure of the risk of treatment but also the nature of the therapy. This is particularly relevant in cases of euthanasia. One agonized by pain and contemplating euthanasia is more concerned with the nature of the treatment proposed than he is with the attendant risks of alternative treatments. It seems unreasonable to expect that an individual would abandon his request for euthanasia for a proposed treatment which, to his limited knowledge, would render him virtually in the same agonizing state. The individual's consent cannot truly be informed if he lacks information concerning the alternatives to euthanasia.

The extent of disclosure necessary to an informed consent has been obfuscated by the rather imprecise language of the courts. The leading case, *Natanson v. Kline,*[166] appears to be the most satisfying under normal circumstances. The court did not require disclosure of all methods and treatments but only new or unusual methods and treatments and the attendant risks involved. This implies, of course, the use of expert witnesses to establish what are the unusual or new methods.[167] In cases involving euthanasia, however, the suggestion of full disclosure of all information that may have any influence on the patient's consent seems the better approach.[168]

The theory under which a perpetrator of euthanasia can be held liable for inadequately disclosing the risks of euthanasia and the alternatives is not clear. The lack of clarity is exemplified by the *Natanson* decision.

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164 *Id.* at 157.
165 251 Minn. 427, 88 N.W.2d 186 (1958).
166 186 Kan. 393, 350 P.2d 1093, *rehearing denied,* 187 Kan. 186, 354 P.2d 670 (1960).
167 *See generally* Note, *Medical Malpractice—Expert Testimony,* 60 Nw. U.L. Rev. 834 (1966).
168 Oppenheim, *Informed Consent to Medical Treatment,* 11 Cleve.-Mar. L. Rev. 249 (1962).

> At times the court speaks of negligence and at times of battery. [I]n the conclusion of the court, any consent that this patient had given was ineffective. This seems to cause the case to turn on the action of trespass to the person. . . .[169]

In comparison, however, in *Williams v. Menehan*,[170]

> [T]he court infers that the law in the *Natanson* case apparently meant that informed consent was, in fact, an action in malpractice and not one in assault and battery.[171]

Procedurally, the action for assault and battery is superior to an action in negligence. In the latter, expert witnesses would be required to testify to the basic standard of conduct of one assuming the status of a physician and his deviation therefrom. In a case of assault and battery, the plaintiff in the wrongful death or survival action could base his cause of action upon his own testimony. This would avoid the problem of obtaining cooperative expert witnesses.

In conclusion, euthanasia presents a problem not formerly existing in tort law. A layman is placed in the position of performing an act which is not expressly within the province of the medical profession. Still, the administration of euthanasia demands the knowledge and training of a physician. One suggestion is to impose the higher standards of the medical profession on the layman if he attempts to administer euthanasia. This would be particularly appropriate in evaluating the perpetrator's defense of consent. Such standards would require the disclosure of the risks and the alternatives to euthanasia before administering it; and acquiescing to the victim's request should not be sufficient to relieve the perpetrator of liability.

E. *Consent to a Criminal Act*

Substantial conflict exists as to whether one who commits a criminal act such as euthanasia with the consent of the victim can be found civilly liable to that victim. According to the doctrine of *volenti non fit injuria*, one has no cause of action for the violation of a right voluntarily waived.[172] However, the majority of jurisdictions recognize an exception if the battery involves a breach of the peace.[173] The basis of this exception comes from the theory that one cannot consent when human life or the public peace is involved.[174] The individual's discretion over his own existence is preempted by the interest of the state in preserving order. Consent, therefore, merely mitigates punitive damages.[175]

There is, however, impressive authority within the legal community subscribing to *volenti non fit injuria* despite a breach of the peace.[176] This view

169 C. WASMUTH AND C. WASMUTH, JR., LAW AND THE SURGICAL TEAM 218 (1969).
170 191 Kans. 6, 379 P.2d 292 (1963).
171 C. WASMUTH AND C. WASMUTH, JR., *supra* note 169, at 220.
172 J. SALMOND, TORTS 38 (11 ed. 1953).
173 Note, *Consent as Affecting Civil Liability for Breaches of the Peace*, 24 COLUM. L. REV. 819, 821 (1924).
174 11 VA. L. REV. 54 (1924).
175 Strawn v. Ingram, 118 W.Va. 603, 191 S.E. 401 (1937).
176 *See generally* W. PROSSER, *supra* note 110, at 107; 1 F. HARPER AND F. JAMES, THE LAW OF TORTS 236 (1956); J. CLERK AND H. LINDSELL, TORTS 342 (13 ed. 1969).

maintains that the victim should not be compensated for the violation of a right he has waived.

This exception to *volenti non fit injuria* which voids an agreement to breach the peace has been traced to dicta,[177] the logic of which is difficult to understand. Since both parties appear at fault and *ex turpi non actio oritur,* there exists little authority for the exception.[178]

Generally then, consent will not be a defense to tort liability for euthanasia. This liability may be avoided if a court analogizes euthanasia to abortion.[179] Most courts have not recognized the mother's right to sue the abortionist if she consented to the abortion.[180] Such an approach is consistent with the refusal of the law to aid either party to an illegal agreement.

Even though a court subscribes to the common law exception imposing liability, a stratagem used by courts to avoid imposing liability is the use of the contract doctrine of *in pari delicto.*[181] Thus, the party who consented to the criminal act is denied the use of the courts to sue. This doctrine has been attacked by some writers where emotional factors affecting a party are present[182] and these factors would probably accompany euthanasia. Such circumstances exist where a devoted husband asphyxiates his cancer stricken wife.[183] If neither *volenti non fit injuria* nor *in pari delicto* apply, a court may permit the jury to consider the circumstances surrounding the consent in mitigation or as a bar to punitive damages.[184]

The exception to *volenti non fit injuria* has been narrowed in the area of euthanasia by developing case law which has expanded the individual's right to refuse medical treatment. Prior judicial thinking restricted this refusal to extraordinary means sustaining life. Such a refusal would usually be recognized only in the case of a comatose patient with irreparable brain damage. However, in *Erickson v. Dilgard,*[185] a New York court in permitting a patient to refuse a blood transfusion apparently condoned the patient's refusal of what by modern medical standards can be classified an ordinary means of sustaining life. Implicitly, the *Erickson* line of thinking encroaches upon established judicial thought by acquiescing in the effectuation of voluntary euthanasia by omission. The extent such precedent is followed and expanded will broaden the defense of consent to the area of civil liability arising from euthanasia. However, the recent case of *John F. Kennedy Memorial Hospital v. Heston*[186] stated that there was no difference between suicide and passively submitting to death. If this holding is followed rather than *Erickson,* the exception to the common law rule of *volenti non fit injuria* will be expanded; especially within the area of the physician-

177 Note, *Consent and Civil Liability for Illegal Abortions,* 45 ILL. L. REV. 395, 397 & n.15 (1950). The exception came from the case Mathew v. Ollerton, Comberback 218 (1693).
178 J. CLARK AND H. LINDSELL, *supra* note 176, at 343.
179 *See* 26 So. CAL. L. REV. 472 (1953).
180 *See supra* note 177, at 395.
181 *See* Smith, *Antecedent Grounds of Liability in the Practice of Surgery,* 14 ROC. MT. L. REV. 233, 273 & n.99 (1942).
182 6A CORBIN ON CONTRACTS § 1537, at 828 (1962).
183 Note 82A, *supra* note 82A.
184 *Cf.* Gaither v. Meacham, 214 Ala. 343, 108 So. 2d (1926).
185 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).
186 58 N.J. 576, 279 A.2d 670 (1971).

patient relationship. This would result since the law would void any consent to means which would permit one to passively die. Therefore, the physician who acquiesces to the refusal of a blood transfusion or the wife or husband who refuses a blood transfusion for an incompetent spouse would be exposed to liability for euthanasia.

F. *Physician-Patient Relationship*

The law imposes upon the physician an affirmative duty to act reasonably toward his patient.[187] A failure to act results in liability for nonfeasance if such failure is unreasonable. If the physician acts unreasonably toward his patient, liability is imposed for misfeasance. Nonfeasance is particularly relevant to imposing liability for euthanasia. This is because of the opportunity available to the physician to "let the patient go" while maintaining a facade of continued treatment.[188] Nonfeasance is a perplexing problem to the physician and, to a limited extent, other relations such as spousal which impose a duty to act. The problem arises because the physician must determine whether the treatment he contemplates discontinuing is, by law, extraordinary or ordinary. Failure to employ a treatment later determined to be ordinary may subject the physician not only to a criminal indictment but also to a malpractice suit.

The physician-patient relationship has been held to arise in contract whether express or implied.[189] These rights and duties are governed by the law of contract.[190] However, it has also been held that there is no necessity for the existence of an express or implied contract for hire.[191]

> [T]he contract between a physician and a patient has a characteristic that makes it different from most other types. . . . It is to hold another to his promise that one makes a contract. That binding quality is what distinguishes a contract from other legal arrangements. Yet the law clearly implies a medical contract . . . can be terminated almost at will. A patient can drop his doctor and thereby terminate his contract at any time. A physician in most cases can end it almost as readily by withdrawing from the case.[192]

Since this relationship once established imposes an affirmative duty to act, the physician may arbitrarily refuse to accept any person as a patient.[193] This applies even though no other physician is available. The point at which this relationship arises is a question of fact. Therefore, a mere rendering of services in an emergency does not necessarily give rise to the relationship.

The peculiarity of this relationship is the absence of reciprocity of rights and

187 W. PROSSER, *supra* note 110, at § 56.
188 Schieldahl, *supra* note 118, at 694.
189 Lumpkin v. Metropolitan Life Ins. Co., 75 Ohio App. 310, 62 N.E.2d 189, *aff'd*, 146 Ohio St. 25, 64 N.E.2d 63 (1945).
190 Spencer v. West, 126 So.2d 423 (La.App. 1960).
191 *See* C. DEWITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT 101 (1958). See also Epstein v. Pennsylvania R.R., 250 Mo. 1, 156 S.W. 699 (1913).
192 C. CUSAMANO, MALPRACTICE LAW DISSECTED FOR QUICK GRASPING 31 (1962).
193 *See* R. MORRIS AND A. MORITZ, *supra* note 137 at 135.

duties which are ascribed to contractual or consensual relationships. The physician controls the rights and duties of the relationship both as to his performance and the patient's. A certain amount of indirect control is also exerted by the standards of the medical community. Unrealistically, the law views the physician-patient relation as one of "mutual participation."[194] The medical community, however, regards such a depiction as foreign to the realities of the practice of medicine.[195] This unilateral control exercised by the physician indicates the need to broaden the physician's responsibility to his patient beyond present standards. A more suitable approach is to impose on the physician a quasi-limited guardianship over the patient to the extent of the proposed treatment. This would extend the physician's liability to all aspects of the treatment rather than limit it to the almost mechanical performance of the treatment chosen. This appears implicit in the holdings of a few courts which impose liability on the physician based on patient-induced treatment.[196] These courts disregarded the defense of the patient's contributory negligence in not submitting to the physician's choice of treatment. This requires a physician to withdraw from a case rather than prescribe a treatment which he regards as medically unfounded. This approval would have significance to euthanasia at a theory of liability when the physician submits to the patient's request to advance death.

IV. Constitutional Law

A. *Framework For Constitutional Analysis*

Each individual has the power to decide whether to terminate or continue his life in the face of incurable or terminal disease. The state, through the exercise or nonexercise of its police power, determines the legal limitations on the exercise of that power.

Theoretically, state law reflects a judgment that the individual's legal prerogative to employ life-terminating practices should be significantly limited. The law concerning suicide in some states forbids both successful, self-inflicted death[197] and unsuccessful attempts at ending life by terminal patients.[198] State homicide laws generally purport to penalize those who terminate the lives of others for humanitarian purposes,[199] and those who assist terminal patients in taking their own lives.[200]

In practice, however, the exercise of the police power by the states exhibits a more liberal attitude toward euthanasia, whether self-inflicted or brought about by another. Obviously, the terminally ill who successfully end their existence, despite the status of suicide in some states as a common law crime, receive no criminal sanction.[201] Nor does the state prosecute those who unsuccessfully

194 Szasz and Hollender, *A Contribution to the Philosophy of Medicine — The Basic Models of the Doctor-Patient Relationship,* 97 ARCHIVES OF INTERNAL MEDICINE 585 (1956).
195 *Id.*
196 *See, e.g.,* King v. Solomon, 323 Mass. 326, 81 N.E.2d 838 (1948).
197 LAFAVE, § 74, 568-69.
198 *Id.* at 569.
199 Annot., 25 A.L.R. 1007 (1923).
200 *E.g.,* People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920).
201 LAFAVE, § 74, 569.

attempt to end life, unless the attempt causes the death of another.[202] Persons perpetrating death upon the terminally ill and those assisting dying patients to end their own lives come under closer scrutiny by the criminal law, if their acts are detected. The state seldom, however, prosecutes such individuals to the fullest extent possible under law. Most cases involving euthanasia deaths conclude in the failure of the grand jury to indict,[203] convictions upon a lesser charge,[204] acquittal upon the defense of insanity,[205] or refusal by the jury to bring in a verdict of guilty.[206]

In examining this present treatment of euthanasia by state law in light of constitutional safeguards to individual rights, several problem areas appear. The dichotomy between the theoretical and practical approach to euthanasia by the states presents a constitutional dilemma. From the perspective of euthanasia victims unwilling or unable to give consent to the premature termination of their lives, the practice of not dealing with perpetrators as the law provides might be viewed as removing standards adequately protecting life by state action, violating both due process and equal protection.[207] From the perpetrator's perspective, however, punishment to the fullest extent provided by law, given the nature of the offense and less severe penalties exacted in most American jurisdictions and other civilized societies, might constitute sanctions unconstitutionally cruel and unusual.[208]

Those terminally ill who desire to prematurely die must contend with the theoretical prohibition imposed by state law. In establishing legal limits upon the discretion to terminate life, the state does not necessarily define the total scope of the individual's right to control his existence under the Constitution. The fourteenth amendment operates to safeguard fundamental rights from arbitrary interference by the states. To regulate the exercise of a fundamental constitutional right, the state must establish a compelling governmental interest for so doing.[209] If the discretion of dying patients over their continued existence enjoys the protection of some fundamental right, present state laws regulating that discretion may be unconstitutional in application, absent some showing of a compelling interest.

Recent proposals before state legislatures to legalize euthanasia[210] indicate an interest in resolving the conflict between the theoretical and practical treatment of that act by state law. Even if a compelling state interest to support current state law exists, state legislatures might redefine that interest to afford more control over existence to patients suffering from terminal or incurable disease. When that legislation includes provisions for terminating the lives of those unable to

202 *Id.* at 569-70.
203 *See, e.g.,* note 82A *supra.*
204 *See, e.g.,* note 82C *supra.*
205 *See, e.g.,* the *Waskin* case, note 82L *supra.*
206 *See, e.g.,* People v. Werner, Criminal No. 58-3636, Cook County Ct., Ill., Dec. 30, 1958.
207 Kutner, *supra* note 103, at 542-43.
208 *Id.* at 549.
209 Bates v. Little Rock, 361 U.S. 516, 524 (1960).
210 *See, e.g.,* H.B. 2914, Fla. Legislature (1971); S.B. 670, S.B. 715, Wis. Legislature (1971).

render legal consent, however, legislatures must consider the strictures of the fourteenth amendment upon taking life without due process of law.

B. *The Constitutional Dilemma*

By present state law standards euthanasia constitutes an intentional taking of life, without provocation or other mitigation, and without justification or excuse. In other words, murder.[211] The administration of those standards, however, exhibits the attitude that euthanasia is less reprehensible than other forms of homicide.[212] Perpetrators, therefore, usually escape the burden of a murder conviction.[213] This dichotomy between theory and practice creates a constitutional dilemma. By failing to treat the perpetrators as murderers, the state may be denying the victims of euthanasia both due process and equal protection of law. By convicting euthanasia perpetrators as murderers, however, the state may be exacting an excessively cruel and unusual punishment.

State law purports to protect terminal patients from having their lives prematurely terminated. State law as applied, however, does not deal with euthanasia perpetrators as murderers. Urging humanitarian motives before the courts, these individuals emerge from the state criminal justice system with no penalty or one significantly less than that prescribed by law for the crime committed.[214] More often, the state never calls upon these individuals to answer for their actions.[215] The state, therefore, has in effect weakened and perhaps removed the safeguard that homicide laws once provided for the life of dying patients.

The fourteenth amendment recognizes the right to life and safeguards it against taking by the state without due process of law. This safeguard protects the individual from more than an affirmative legislative assault upon the sanctity of human existence, as Justice Staley explained in *Vanderbilt v. Hegeman*.[216]

> The right to life . . . includes more than mere freedom from personal harm . . . by direct operation of enactments of the Legislature. A person may be deprived of life . . . by the removal of those safeguards which restrain one individual from violating the personal rights of others.[217]

State laws prohibiting murder and the penalties prescribed for their violation are designed to deter individuals from intentionally taking the life of others.[218] When the administration of those laws permits perpetrators of euthanasia to proceed without fear of punishment, no adequate legal safeguards for the lives of their victims exist. The application of the law, therefore, constitutes state action depriving life without due process.

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211 1 F. INBAU, J. THOMPSON, & C. SOWLE, CASES AND COMMENTS ON CRIMINAL JUSTICE 403 (3d ed. 1968).
212 *Id.* at 404.
213 Morris, *Voluntary Euthanasia,* 45 WASH. L. REV. 239, 242 n.7 (1970).
214 *Id.*
215 The prosecuting authorities have long preferred not to prosecute those accused of euthanasia homicides. As an early legal encyclopedia explained: "When the act which immediately produces death is meritorious in character, prosecuting officers will hardly make it the foundation of a criminal prosecution." 13 R.C.L. *Homicide* § 36, at 734 (1916).
216 157 Misc. 908, 284 N.Y.S. 586 (1935).
217 *Id.* at 911, 284 N.Y.S. at 590.
218 Note, 69 YALE L.J. 1453, 1455 (1960).

The most glaring violation of due process rights occurs when the patient does not choose to have his life prematurely terminated. Whether because of religious belief, hope for a miraculous recovery, or fear of death, some terminal patients choose to live in the face of little or no hope of cure. Also unconsciousness and mental derangement brought on by extreme pain or drugs render some patients incapable of intelligently choosing to have their existence terminated. Those closely involved with the patients, however, such as physicians or relatives, sometimes favor premature death. Their motives may be commendable—such as preventing needless pain—or not so laudable—such as hastening an inheritance. Therefore, as the life-terminating stroke can be administered without the victim's awareness, and since state law no longer deters its administration, the unwilling or unconsenting victims have no effective safeguards for their existence.

The lack of safeguards provided by state law for the lives of dying patients also presents an equal protection problem. The fourteenth amendment, in section one, guarantees to individuals equality before state law. This guaranty doesn't deprive the states of the prerogative to treat different classes of people in different ways, so long as such a classification is fair and reasonable.[219] If the state, however, bases its classification upon characteristics over which the individual has no control, a mere accident of condition which fades into insignificance in the face of common humanity, that classification is inherently unreasonable and violates equal protection.[220] Also, if the state prohibits the exercise of a fundamental right by a certain group, it must demonstrate a compelling state interest for so doing.[221] The Equal Protection Clause scrutinizes state laws both on the face[222] and in application.[223]

The application of present state homicide laws to euthanasia perpetrators denies patients in a terminal condition equal protection of law. States, by failing to deal with those practicing euthanasia upon dying patients as murderers, remove the deterrent effect of homicide laws. This leaves the terminally ill without adequate legal safeguards to their right to live, although state sanctions still deter the killing of those not so situated. Such a classification is inherently suspect. It categorizes individuals on the basis of their physical condition, a basis that appears no more acceptable than other classifications based on physical differences found inherently unreasonable, such as race[224] and sex.[225] Also, a compelling state interest for removing state protection to human existence seems absent. The right to live enjoys the constitutional status of fundamental.[226] Given the attitude toward the sanctity of life exhibited by state laws prohibiting homicide, the state must show some compelling reason for denying the protection of those laws to terminal patients. The rationale for depriving such safeguards ap-

219 *See* Reed v. Reed, 404 U.S. 71, 76 (1971).
220 B. SCHWARTZ, CONSTITUTIONAL LAW § 154, at 293 (1972).
221 *See* Shapiro v. Thompson, 394 U.S. 618, 634 (1969).
222 *See* Strauder v. West Virginia, 100 U.S. 303, 308 (1880).
223 *See* Yick Wo v. Hopkins, 118 U.S. 356, 373 (1886).
224 *See* Strauder v. West Virginia, 100 U.S. 303, 310 (1880).
225 *See* Reed v. Reed, 404 U.S. 71, 76-77 (1971).
226 For discussion of the constitutional status of the right to life, *see* Note, *In Defense of the Right to Live: The Constitutionality of Therapeutic Abortion,* 1 GA. L. REV. 693, 697-99 (1967); Note, *The Unborn Child and the Constitutional Conception of Life,* 56 IOWA L. REV. 994, 996, 1003-04 (1971).

pears to be a feeling among a substantial segment of the populace that such a homicide should not be considered murder. The sentiment of the majority, however, cannot constitute a compelling governmental interest for depriving individuals of constitutionally protected rights.[227] Since the right to life may be deprived by the state through the removal of adequate legal safeguards to that right, the present administration of state homicide laws in regard to euthanasia denies to the victims of that practice equal protection of law.

If the states enforce homicide laws and convict euthanasia perpetrators as murderers, imposing sentences of death or life imprisonment, they may be subjecting these persons to unconstitutional forms of punishment. In most American jurisdictions, a conviction of murder in the first degree carries a sentence of life imprisonment or death, imposed at the discretion of the jury hearing or the judge presiding over the case.[228] The eighth amendment of the Bill of Rights, however, protects those convicted from punishments cruel and unusual.[229] This constitutional guaranty safeguards the convicted from punishments inherently cruel and unusual, penalties of such character as to shock the general conscience and to violate principles of fundamental fairness,[230] and those cruel and unusual by their excessiveness, sentences disproportionate to the offense committed.[231]

The Supreme Court recently scrutinized the death penalty in light of the eighth and fourteenth amendments in *Furman v. Georgia*.[232] The appellants attacked the imposition of the death penalty for the crimes of murder and rape, under statutes giving sentencing discretion to the presiding judge or jury, as unconstitutional.[233]

The majority of the Court agreed with the appellants, but couldn't concur upon a rationale for so holding. Justices Brennan and Marshall contended that the imposition of the death penalty was cruel and unusual punishment per se.[234] Justices Stewart and White, however, rendered a narrower decision, holding the death penalty only cruel and unusual as presently imposed under statutes giving judge or jury the prerogative to choose between execution or life imprisonment.[235] Justice Douglas concurred on equal protection grounds. The remainder of the Court, in four separate opinions, dissented finding the death penalty neither inherently cruel and unusual nor unconstitutionally excessive.[236]

With six justices holding the death penalty not cruel and unusual per se, the *Furman* decision places the fate of the death penalty in the United States in question. Some states, keying on language in the concurring opinion of Justices Stewart and White, are considering new legislation designating the death penalty

227 *See* Lucas v. Colorado Gen. Assembly, 377 U.S. 713, 736 (1964); Board of Education v. Barnette, 319 U.S. 624, 638 (1943).
228 *E.g.*, CAL. PENAL CODE § 190 (West 1970); ILL. STAT. ANN. ch. 38 § 9-1(b) (1972); *Mass. Ann. Laws* ch. 265, § 2 (1968); N.C. GEN. STAT. § 14-17 (1969); PA. STAT. ANN. tit. 18, § 1102 (1973).
229 U.S. CONST. amend. VIII.
230 Lee v. Tahash, 352 F.2d 970, 972 (1965).
231 Weems v. United States, 217 U.S. 349, 377 (1910).
232 408 U.S. 238 (1972).
233 *Id.* at 240.
234 *Id.* at 257, 314 (concurring opinions).
235 *Id.* at 306, 310 (concurring opinions).
236 *Id.* at 375, 405, 414, 465 (dissenting opinions).

as the statutorily imposed sentence for conviction of certain specific crimes.[237] This would probably not affect those practicing euthanasia, as some legislatures have already demonstrated a willingness to consider, at least at the committee level, bills legalizing the practice of euthanasia in certain prescribed circumstances.[238]

The *Furman* decision, however, does place a majority of the Court behind the opinion that the death penalty imposed at the discretion of judge or jury constitutes cruel and unusual punishment. Euthanasia perpetrators convicted of first degree murder and sentenced to death could presently expect a coalition of those justices opposing the death penalty regardless of how imposed and those against such sentencing when judge or jury choose between death or life imprisonment to reverse such punishment as unconstitutional. A change in personnel on the Court, however, may cause this rationale to be reconsidered.

The concurring opinions in *Furman* present a compelling case for holding the death penalty, at least as imposed under most first degree murder statutes, cruel and unusual. Justices Brennan and Marshall viewed the death penalty, whether imposed by statute or the discretion of judge or jury, as cruel and unusual.[239] Although holding that death sentences constitute punishment inherently cruel and unusual, they concentrated primarily upon the arbitrary and excessive nature of the penalty[240]—key elements in the pivotal opinions of other justices concurring on eighth amendment grounds. Justices Stewart and White also chose to focus their analysis upon the arbitrary and excessive aspects of the punishment, but limited the scope of their constitutional condemnation to sentences imposed by judges or juries having the statutory prerogative to choose between life imprisonment and execution.[241]

Mr. Justice Stewart adopted essentially a definitional approach. He felt the death penalty "cruel" because it exceeded the punishment deemed necessary by the state for the crime in question.[242] By giving the judge or jury the choice the state implicitly admitted that the death penalty went beyond that necessary to accomplish society's penal purposes.[243] He considered the death sentence "unusual" because of its infrequent imposition. His opinion pointed out that the penalty of death is "infrequently imposed for murder"[244] and "its imposition for rape is extraordinarily rare."[245] Those upon whom the burden of the penalty rests he termed a "capriciously selected random handful."[246]

Justice White concentrated upon the excessiveness of the death sentence meted out at the discretion of judges and juries. Echoing Justice Stewart's analysis, he emphasized that the legislative will, the official determination of the punishment necessary to accomplish the state's penal purposes, is not frustrated

237 NEWSWEEK, Dec. 18, 1972, at 23-24.
238 *See* proposed legislation cited in note 209 *supra.*
239 Furman v. Georgia, 408 U.S. 238, 257, 314 (1972) (concurring opinions).
240 *Id.*
241 *Id.* at 306, 310 (concurring opinions).
242 *Id.* at 309.
243 *Id.* at 314.
244 *Id.* at 309.
245 *Id.*
246 *Id.* at 309-10.

when the trial court chooses not to impose the death penalty.[247] He then proceeded to examine each of the penal purposes held by the state to determine whether death excessively punished the convicted in seeking to achieve those purposes. Speaking of deterrence, Justice White concluded:

> . . . a major goal of the criminal law—to deter others by punishing the convicted criminal—would not be substantially served where the penalty is so seldom invoked that it ceases to be the credible threat essential to influence the conduct of others.[248]

He then discussed retribution, commenting that the infrequency with which judges and juries gave out death sentences exhibited doubt "that any existing general need for retribution would be measurably satisfied" by that punishment.[249] Moving on to specific deterrence of the perpetrator Mr. Justice White commented that society's need does not justify "death for so few when for so many in like circumstances life imprisonment or shorter prison terms are judged sufficient."[250] Finally he summarizes his conviction by offering:

> At the moment that it ceases realistically to further these [penal] purposes . . . its imposition would then be the pointless and needless extinction of life with only marginal contributions to any discernible social or public purposes.[251]

Justice White apparently believed that moment had arrived.[252]

All these concurring opinions present analysis particularly applicable to euthanasia perpetrators who might be convicted of murder and sentenced to die. The prohibitions against the death penalty staked out by Justices Brennan and Marshall cover all death sentences,[253] and, therefore, provide constitutional protection to those ending the lives of the terminally ill with humanitarian motives. Under Justice Stewart's definitional approach, the death penalty constitutes "cruel" punishment, since the states have traditionally treated those practicing euthanasia less severely than others committing murder. The sentence would also qualify as "cruel" punishment, given that no person convicted of murder for a euthanasia-type homicide has ever actually been executed.[254] Utilizing Justice White's rationale, the death sentence for those convicted of practicing euthanasia would excessively punish the perpetrators while minimally contributing to the achievement of the state's penal purposes. Since American states have never sent a euthanasia perpetrator to his death, they cannot claim any deterrent value brought about by doing so. Nor can retribution warrant the punishment, since those close to the victim often favor a premature death to spare needless agony or at least acquiesce should the dying patient request it.[255] Specific deterrence

247 *Id.* at 311.
248 *Id.* at 312.
249 *Id.* at 311.
250 *Id.* at 311-12.
251 *Id.* at 312.
252 *Id.* at 314.
253 *Id.* at 257, 314 (concurring opinions).
254 *See* note 83 *supra.*
255 The theory of retribution as applied to homicide law posits that if the perpetrator escapes just punishment, the relatives and friends of the victim will take the law into their own

provides no stronger rationale, given that the courts on so many other occasions have determined lesser sentences sufficient.[256] Finally, the state cannot consider the perpetrators beyond rehabilitation, since those convicted of murder seldom commit a similar offense upon release.[257] The death penalty does not, then, present an effective means of accomplishing state penal objectives, especially when considered in light of euthanasia and, therefore, imposes an unconstitutionally cruel and unusual punishment upon those convicted of murder for ending the lives of the incurably ill.

Life imprisonment remains a possibility for those practicing euthanasia who find their way before American courts of law on homicide charges. Life sentences have occasionally been given to those actually convicted of such crimes.[258] In a time when American society has come to view euthanasia as an act distinct from murder, and other civilized societies legally recognize it as less reprehensible than murder,[259] the life sentence for killing another under merciful pretenses should be reexamined in light of the constitutional guaranty against cruel and unusual punishments.

Traditionally, life imprisonment has withstood attack as inherently cruel and unusual punishment.[260] When challenged as excessive, however, the penalty seems more vulnerable. Scrutinizing punishments as excessively cruel and unusual, courts question whether the offense committed warrants the sentence imposed. Two approaches have evolved to aid the courts in making this decision.[261] The comparative approach sets as the standard sentences for the same or similar offenses imposed in other systems of law.[262] Sentences emerge as unconstitutional if grossly excessive to those prevalent in comparable jurisdictions. The second approach examines the punishment in light of the penal purposes the state seeks to accomplish by imposing it, and inquires whether the penalty in question goes beyond that necessary to achieve those purposes.[263]

The Supreme Court has never defined with exactness the scope of the constitutional phrase "excessively cruel and unusual," but the Court has made clear the dynamic nature of the concept, mandating that the meaning be drawn from "the evolving standards of decency that mark the progress of a maturing

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hands and deal with the wrongdoer accordingly. *See generally* O. W. HOLMES, THE COMMON LAW 45 (1923); Cohen, *Moral Aspects of the Criminal Law*, 49 YALE L.J. 987, 1009-1012 (1940). Interestingly enough, many acts of euthanasia which have come to trial have been perpetrated by relatives of the victims. *See, e.g.*, Kamisar, *supra* note 2, at 1020-22 nn.173, 180-83.

256 *See* the table outlining sentences given to euthanasia perpetrators by various American courts in Morris, *supra* note 212.

257 Furman v. Georgia, 408 U.S. 238, 355 (1972) (Marshall, J., concurring).

258 *See, e.g.*, People v. Roberts, 211 Mich. 187, 193, 178 N.W. 690, 692 (1920).

259 For a comparison of the treatment given euthanasia by European systems of law with that afforded by American jurisdictions, *see* Silving *supra* note 2, at 350.

260 *See, e.g.*, Green v. Teets, 244 F.2d 401 (9th Cir. 1957); State v. Taylor, 82 Ariz. 289, 312 P.2d 162 (1957); In re Rosencrantz, 205 Cal. 534, 271 P.902 (1928); State v. Custer, 240 Ore. 350, 401 P.2d 402 (1965). *But see* Workman v. Commonwealth, 429 S.W.2d 374 (Ky. 1968).

261 For an extensive discussion of these approaches, *see* Note, *Revival of the Eighth Amendment: Development of Cruel-Punishment Doctrine by the Supreme Court*, 16 STAN. L. REV. 996, 1003-11 (1964).

262 Weems v. United States, 217 U.S. 349, 380-81 (1910).

263 Furman v. Georgia, 408 U.S. 238, 279 (1972) (Brennan, J., concurring).

society."[264] The Court first sought to ascertain these standards by looking to sentencing practices in other systems of law. In *Weems v. United States*[265] Justice McKenna, speaking for the majority, held that the statutory penalty under the Philippine Code for falsifying an official document—twelve years and one day of *cadena temporal,* with fines and accessories[266]—constituted punishment so disproportionate to the offense committed as to be cruel and unusual. He arrived at this conclusion by comparing the Philippine sentence with those given for similar offenses under the Philippine Code and in American jurisdictions.[267] This decision could provide a basis for declaring punishments unconstitutionally excessive by showing them contrary to the practice prevalent in most American jurisdictions and other sophisticated legal systems. This reasoning has yet to develop. Justice Holmes rejected it in *Badders v. United States,*[268] citing *Howard v. Fleming*:[269]

> That for other offenses, which may be considered by most, if not all, of a more grievous character, less punishments have been inflicted does not make this sentence cruel.[270]

More recently, in *Furman v. Georgia,* none of the opinions holding the death penalty excessively cruel and unusual punishment relied upon the comparative approach.[271]

The Court has developed, however, a second approach in later cases striking down punishments as unconstitutionally cruel and unusual. Justice Brennan in *Furman v. Georgia* explained it stating:

> If there is a significantly less severe punishment adequate to achieve the purposes for which the punishment is inflicted . . . the punishment inflicted is unnecessary and therefore excessive.[272]

Utilizing this approach, the courts examine the accepted purposes for criminal sentences[273]—general deterrence, specific deterrence, retribution, and rehabilitation—in light of the penalty imposed to ascertain whether a lesser punishment might suffice. Should the court determine a less severe penalty adequate or find that the sentence given fails to further appropriate penal objectives, the punishment in question is dismissed as cruel and unusual.[274]

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264 Trop v. Dulles, 356 U.S. 86, 101 (1958).
265 217 U.S. 349 (1910).
266 In *Weems* the appellant, convicted of falsifying public documents, was sentenced to fifteen years of hard labor chained by the ankle (*cadena temporal*), plus a fine of four thousand pesos and certain accessories, including perpetual disqualification from holding public office and from voting. *Id.* at 364-65.
267 *Id.* at 380-81.
268 240 U.S. 391, 394 (1916).
269 191 U.S. 126 (1903).
270 *Id.* at 135-36.
271 *E.g.,* 408 U.S. 238, 278 (1972) (Brennan, J., concurring).
272 *Id.* at 279.
273 Note, 69 YALE L.J. 1453, 1455 (1960).
274 *See* Note, *supra* 261, at 1011-14, for an example of how this approach was utilized in *Robinson v. California,* 370 U.S. 660 (1962), to strike down a California law making narcotics addiction a crime.

The imposition of a life sentence for perpetrating euthanasia might prove excessively cruel and unusual under either approach available to the courts. Although the comparative approach presently remains dormant, a comparison with the present practice in American jurisdictions and foreign legal systems shows the sentence excessive by contemporary standards. No state has resorted to life imprisonment as a penalty for euthanasia since the *Noxon* case in 1946, and even that sentence was commuted within three years to six years to life, followed shortly thereafter by parole.[275] Likewise, many foreign countries have abandoned the life term as punishment for euthanasia.[276] German law treats euthanasia as a lesser offense, not encompassed by prohibitions against murder.[277] In Switzerland, the judge may mitigate the sentence for a homicide perpetrated with honorable motives.[278] Similarly, Norwegian law provides judges with discretion comparable to that of the Swiss bench.[279] Life imprisonment for euthanasia, therefore, appears excessive in light of American and foreign criminal justice practices.

The life sentence for practicing euthanasia also seems excessive when examined in light of the purposes states seek to achieve through penal sanctions. Given the infrequency with which the penalty is imposed, Justice White's analysis in *Furman v. Georgia* seems applicable to life imprisonment for those convicted of practicing euthanasia.[280] The general deterrent value of the penalty seems doubtful, considering that American courts have been reluctant to convict perpetrators of crimes carrying the sentence or fail to execute it when the penalty is given.[281] Likewise, life imprisonment appears unnecessary as a specific deterrent since the states have determined lesser penalties, if any, sufficient in so many other cases.[282] Nor does retribution necessitate such punishment, as those closest to the victims often favor a premature and merciful death, or at least acquiesce where the dying patients choose such an ending.[283] Imposing life sentences on those who bring premature death to terminal patients adds little to the accomplishment of any of these penal objectives, and, therefore, violates the eighth amendment ban on cruel and unusual punishments.

Challenging the life sentence as unconstitutional, however, may present difficulties. Most successful challenges on eighth amendment theories contest the validity of the statute on its face.[284] This necessitates a showing that the penalty imposed by the statute is disproportionate to the crime prohibited.[285] Since American criminal law does not consider euthanasia an offense separate from murder,[286] an attack upon life imprisonment on-the-face would necessarily challenge that sentence as disproportionate to the crime of murder. Chances of

275 *See* Morris, *supra* note 213, at 242 n.7c.
276 *See, generally,* Silving, *supra* note 2.
277 *Id.* at 365 n.55.
278 Swiss Penal Code art. 63, cited in Silving, *supra* note 2, at 367 n.62.
279 J. GOULD & L. CRAIGMYLE, YOUR DEATH WARRANT? 28 (1971).
280 408 U.S. 238, 312.
281 *See* Morris, *supra* note 213.
282 *Id.*
283 *See* note 255 *supra.*
284 *See* Annot., 33 A.L.R. 3d 335, 359 (1970).
285 *Id.* at 357.
286 1 F. INBAU, J. THOMPSON, & C. SOWLE, *supra* note 211.

success on this basis are slim. Many courts refuse to uphold challenges to statutes as applied on an eighth amendment theory, holding that a sentence within the limits of a valid statute cannot be cruel and unusual in the constitutional sense.[287] A minority of jurisdictions, however, permit such contests. Courts in these states have held that the prohibition against cruel and unusual punishments extends to the judiciary as well as the legislature.[288] Even though a sentence is within the maximum prescribed by statute, it may be so disproportionate to the offense actually committed as to be completely shocking and arbitrary to the sense of justice and, therefore, should be reversed as unconstitutional.[289] This conclusion seems not only reasonable but necessary, given that the fourteenth amendment, which makes the eighth applicable to the states, checks state courts as well as legislatures.[290]

The states, in trying to deal with euthanasia under present law, face a constitutional dilemma. Because so few incidences of the practice actually find their way before trial courts, and fewer yet move up to the appellate level, this dilemma may never haunt the states through an appellate decision exposing the constitutional inadequacies of not punishing perpetrators on one hand, and punishing them on the other. Nevertheless, the present state law approach, both in theory and application, fails to provide adequate safeguards for the constitutional rights of euthanasia perpetrators and their victims, and this dilemma should be pondered when the states consider new approaches to the practice through legislation.

C. *A Constitutional Right to Die?*[291]

Persons afflicted with terminal or incurable illness seeking to forego further bodily pain and futile life-prolonging treatments may have some constitutional protection from state interference. The right to privacy, derived from the ninth and fourteenth amendments, has received consideration as a possible safeguard against state-imposed measures to prolong life for those near death who wish to die prematurely.[292]

In *Griswold v. Connecticut*[293] the Supreme Court first recognized the right

287 *See, e.g.*, Rener v. Beto, 447 F.2d 20 (5th Cir. 1971), *appeal dismissed*, 405 U.S. 1051 (1972); Smith v. United States, 407 F.2d 356 (8th Cir. 1969), *cert. denied*, 395 U.S. 966 (1969); United States v. Martell, 335 F.2d 764 (4th Cir. 1964); Lindsey v. United States, 332 F.2d 688 (9th Cir. 1964).

288 Cox v. State, 203 Ind. 544, 558, 181 N.E. 469, 472 (1932).

289 Faulkner v. State, 445 P.2d 815, 818 (Alas. 1968).

290 *See* Shelley v. Kraemer, 334 U.S. 1, 14 (1948); Brinkerhoff-Faris Co. v. Hill, 281 U.S. 673, 680 (1930).

291 This section deals primarily with the substantive issue of whether the discretion of terminal patients to prematurely end life enjoys any constitutional protection. *See generally* Note, *Legal Aspects of Euthanasia, supra* note 106, at 686-87, concerning justiciability and standing questions related to this substantive inquiry.

292 *Id.* at 683-86. The right to privacy as used in this discussion prevents the states from interfering with certain aspects of the lives of private individuals. The term itself, however, has a broader meaning and includes the right of individuals to be free from certain intrusions by other persons and nongovernmental entities. *See* Dixon, *The Griswold Penumbra: Constitutional Charter for an Expanded Law of Privacy?* 64 MICH. L. REV. 197, 199-202 (1965), for an explanation of the term "right to privacy" as used in the private as well as the public law sense.

293 381 U.S. 479 (1965).

to privacy as a fundamental constitutional guarantee. In that case, the Court invalidated a Connecticut statute prohibiting the use of contraceptives by married couples and the distribution of birth control information and devices to them as violative of the fundamental right to privacy. The majority rendered four separate opinions, upholding that right under three distinct theories.

Mr. Justice Douglas, giving the opinion of the Court, viewed the right to privacy as constitutionally created.[294] Referring to several amendments among the first ten, he explained:

> . . . specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. . . . Various guarantees create zones of privacy.[295]

Justice Douglas reasoned, therefore, that although the Constitution nowhere specifically mentions a right to privacy, various guarantees that are expressly stated embody aspects of that right essential to their viability.[296] The right of association[297] and the right to travel freely within the United States[298] have achieved recognition as fundamental constitutional rights in the same way.

Justice Goldberg, however, concentrating his analysis on the ninth amendment, rejected that provision as an independent source of rights protected from state and federal interference.[299] He preferred to view the ninth amendment as an expression by the Constitution's authors that certain personal rights, those so rooted in the traditions and collective conscience of our society as to be considered fundamental,[300] should not be denied simply because they are not expressly stated in the first eight amendments.[301] Justice Goldberg classified the right to privacy as one of those unenumerated rights, emanating ". . . from the totality of the constitutional scheme under which we live."[302]

Justices Harlan and White, concurring in separate opinions, chose to uphold the challenge to the Connecticut statute through the fourteenth amendment.[303] In doing so, Mr. Justice Harlan sought to reaffirm the principle that due process can serve as a vehicle for protecting rights not specifically mentioned in the Constitution.[304] Justice White also seized upon due process as a means to provide constitutional protection for unenumerated rights, designating the right of married couples to receive and use contraceptives as encompassed under the concept of "liberty."[305] Neither opinion specifically referred to a "right to privacy," but both offered a substantive due process approach for protecting rights not enumerated in the Constitution.

294 *Id.* at 484.
295 *Id.*
296 *Id.*
297 *Id.*
298 United States v. Guest, 383 U.S. 745, 759 (1966).
299 *See* Emerson, *Nine Justices in Search of a Doctrine,* 64 MICH. L. REV. 219, 227 (1965).
300 381 U.S. at 487.
301 Kauper, *Penumbras, Peripheries, Emanations, Things Fundamental and Things Forgotten: The Griswold Case,* 64 MICH. L. REV. 235, 245 (1965).
302 381 U.S. at 494.
303 *Id.* at 499, 502.
304 Kauper, *supra* note 301, at 246.
305 *Id.* at 246-47.

Two standards emerged from *Griswold* for determining when state regulation unconstitutionally inhibits the exercise of unenumerated, fundamental rights. Justice Douglas chose to invalidate the statute in question as overbroad, declaring:

> . . . a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.[306]

The states, therefore, while permissibly regulating conduct under the police power must not use methods which stifle the exercise of fundamental rights. Justice Goldberg, however, applied a different standard, requiring the states to demonstrate a compelling interest for restricting the exercise of such rights.[307] He found support for this view from Justice Harlan, who required closer scrutiny than the rationality test provided when a statute abridged fundamental rights,[308] and Mr. Justice White, who demanded "substantial justification" for state action abridging protected liberties.[309]

The Supreme Court in *Griswold* did not define the scope of the constitutional right to privacy but left its boundaries to be determined on a case-by-case basis. To ascertain whether this unenumerate right—this constitutional guarantee —provides any constitutional endorsement for acts cutting short the lives of terminal patients, cases construing it must be examined.

Recent cases utilizing the right to privacy to uphold personal liberties seem to indicate the recognition of a right to control one's own body. The common law acknowledges this prerogative, protecting the individual from undergoing medical treatment to which he has not consented, except in emergency situations where the patient is unable to give consent.[310] In *Erickson v. Dilgard,*[311] a New York court applied this principle to a situation in which refusing a blood transfusion placed a patient in danger of death. Upholding the right of the patient to refuse treatment, the court asserted that under our system of government, the individual subject to a medical decision must be free to make it, so long as he is competent to do so.[312] Recently a Florida Circuit Court, in *Palm Springs General Hospital, Inc. v. Martinez,*[313] refused a hospital's petition for a court order requiring a 72-year-old woman to have a minor operation to prepare her collapsed veins for a life-prolonging blood transfusion. The court made clear its belief that a competent adult could not be forced to endure unwanted treatment, even though the best medical opinion might consider it essential to prevent death.[314] Likewise the District of Columbia Court of Appeals in a recent decision upheld the prerog-

306 381 U.S. at 485.
307 *Id.* at 497.
308 Poe v. Ullman, 367 U.S. 497, 554 (1961) (Harlan, J., dissenting). Although Justice Harlan did not specifically address this question while concurring in *Griswold,* his dissent in *Poe v. Ullman,* an earlier case challenging the same statute struck down in the *Griswold* decision, indicated that he favored a higher standard for scrutinizing state interests used to justify intrusions upon marital privacy.
309 381 U.S. at 503-4.
310 *See* R. MORRIS & A. MORITZ, *supra* note 137, at 151-52.
311 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).
312 *Id.* at 706.
313 Case No. 71-12678, Cir. Ct. of Dade County, Fla., July 2, 1971.
314 *Id.*

ative of a competent patient to refuse a blood transfusion by rejecting the plea of hospital officials to appoint a guardian to authorize the treatment.[315] Although the majority concentrated on the patient's right to reject the transfusion based on his religious beliefs,[316] a concurring opinion emphasized that the court's decision could be justified on "the broader based freedom of choice, whether founded on religious beliefs or otherwise."[317] These decisions do not specifically call the discretion afforded to these patients the "right to privacy," but nevertheless express the belief that these persons should be able to make their decisions to reject treatment free from interference by the government.

Numerous state and federal court opinions striking down statutes prohibiting the abortion of an unquickened fetus have looked to the right to privacy as developed in *Griswold v. Connecticut* for justification.[318] Some of these cases, such as *Doe v. Bolton*[319] and *YWCA v. Kugler,*[320] draw upon the right to privacy generally without commenting upon the source for that right. Others, however, including *Roe v. Wade*[321] and *Babbitz v. McCann,*[322] point specifically to the ninth amendment as protecting the right of a pregnant woman to determine whether to continue or terminate her pregnancy before the embryo has quickened. Although most of these cases speak of this prerogative as among matters pertaining to procreation, marriage, the family, and sex encompassed by the zone of privacy protected under the Constitution, *Doe v. Scott*[323] goes on to speak of the right to privacy as including a woman's right "to control over her body."[324] At the very least these cases uphold a woman's prerogative to control the reproductive functions within her body.[325]

As the abortion cases readily admit, however, any right to control over one's body that might exist may be limited by the states upon the showing of a compelling interest.[326] The question remains as to what interests can be considered compelling. Cases ruling upon the right to refuse treatment because of religious beliefs may provide the answer.[327] The right to privacy, established as fundamental in *Griswold,* enjoys equal constitutional status with first amendment rights, which served as the basis for refusing treatment in those cases. Therefore, any interest compelling enough to overcome the fundamental right of free religious

315 In Re Osborne, 294 A.2d 372 (D.C. App. 1972).
316 *Id.* at 375.
317 *Id.* at 376.
318 Recently the Supreme Court in *Roe v. Wade,* 41 U.S.L.W. 4213 (U.S. Jan. 22, 1973), utilized the right to privacy to protect the discretion of pregnant women to have abortions on demand, during the first trimester of gestation, against state interference.
319 41 U.S.L.W. 4233 (U.S. Jan. 22, 1973).
320 342 F. Supp. 1048 (D.N.J. 1972).
321 314 F. Supp. 1217 (N.D. Tex. 1970), *aff'd,* 41 U.S.L.W. 4213 (U.S. Jan. 22, 1973). The Supreme Court expressed a preference for a fourteenth amendment foundation for the right to privacy rather than using the ninth amendment basis recognized by the district court. 41 U.S.L.W. at 4225.
322 310 F. Supp. 293 (E.D. Wis. 1970), *vacated on other grounds,* 402 U.S. 903 (1971).
323 321 F. Supp. 1385 (N.D. Ill. 1971), *appeal docketed,* 41 U.S.L.W. 3018 (U.S. July 11, 1972) (No. 70-106).
324 321 F. Supp. at 1389.
325 23 VAND. L. REV. 1346, 1352 (1970).
326 Poe v. Menghini, 339 F. Supp. 986, 993 (D. Kan. 1972).
327 *See generally* Annot., 9 A.L.R. 3d 1391 (1966); Note, *An Adult's Right to Resist Blood Transfusions: A View Through John F. Kennedy Memorial Hospital v. Heston,* 47 NOTRE DAME LAWYER 571 (1972).

exercise would also suffice to outweigh any liberties asserted under the right to privacy.

In *Application of President and Directors of Georgetown College*[328] the United States Court of Appeals for the District of Columbia upheld a court order requiring a mother with minor children to submit to a blood transfusion, despite her religious beliefs forbidding such medical treatment. The court presented several rationales for sustaining the order which may serve as compelling interests sufficient to overcome fundamental rights.[329] First, the patient was in *extremis* and hardly *compos mentis* when rejecting the transfusion, permitting the court to analogize her condition to that of a minor whose parents refuse to give consent for treatment and to evoke the state interest in preserving the lives of those not competent to provide for their own welfare.[330] Second, since the patient had minor children, the court called upon the interest of the state as *parens patriae* in preventing those minors from becoming wards under its charge to prohibit a rejection of treatment, which might result in the patient's death.[331] Finally, the court purported to permit the transfusion to protect the hospital and medical personnel involved from potential civil and criminal liability for letting the patient die without rendering appropriate medical treatment.[332] The *Georgetown* case, then, presents three potential interests compelling enough to overcome an individual's prerogative to refuse treatment founded upon a fundamental constitutional right.

A United States District Court in Connecticut, in *United States v. George*,[333] suggested another state interest sufficient to override the right to withhold consent for medical treatment. In that case the father of four minor children refused to receive a blood transfusion because it conflicted with his religious tenets.[334] The court regarded the patient's competency to make that choice in doubt, but emphasized that even if the man were coherent and rational his right to reject the transfusion would not be absolute.[335] The state has an interest in upholding respect for the doctor's conscience and professional oath, and therefore must not require physicians to forego doing that which their responsibility requires.[336] The New Jersey Supreme Court in *John F. Kennedy Memorial Hospital v. Heston*[337] also expressed concern for respecting physicians' judgment as to their professional responsibility in rejecting a challenge to a court order requiring a blood transfusion against a patient's will.

Another setting in which the state might prevail over a patient desiring to reject treatment appeared in *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*.[338] In that case a woman in the thirty-second week of pregnancy desired to

328 331 F.2d 1000 (D.C. Cir. 1964), *rehearing en banc denied*, 331 F.2d 1010 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964).
329 *Id.* at 1009.
330 *Id.* at 1008.
331 *Id.*
332 *Id.* at 1009.
333 239 F. Supp. 752 (D. Conn. 1965).
334 *Id.* at 753.
335 *Id.* at 754.
336 *Id.*
337 58 N.J. 576, 582, 279 A.2d 670, 673 (1971).
338 42 N.J. 421, 201 A.2d 537 (1964), *cert. denied*, 377 U.S. 985 (1964).

avoid a blood transfusion as contrary to her religious beliefs.[339] The court held the transfusion so integral to the safety of both the woman and the quickened fetus that the state might intervene to order the treatment.[340] The decision offered no opinion as to whether the woman could have rejected the transfusion had she not been pregnant.

There do exist, and courts have recognized, certain compelling interests overriding the right to control one's own body. These interests may not appear so substantial, however, when examined in light of those suffering from terminal or incurable disease desiring premature death. American society strongly affirms the sanctity of human life[341] and, therefore, no fundamental right could probably stay the hand of the state from prohibiting terminal patients from employing active measures to prematurely terminate life.[342] Such persons may, however, enjoy the right to refuse both ordinary and extraordinary treatments designed to prolong existence.

As the cases involving blood transfusions and religious beliefs demonstrate, the most compelling state interest involved where patients desire to refuse medical treatment is preserving the sanctity of human life. This interest underlies the concern of the various courts in the criminal and civil liability of doctors and the well-being of those unable to render intelligent consent. That refusing extraordinary treatment does not endanger the sanctity of life can be shown by looking to the pronouncements of the Roman Catholic Church, one of the most vigorous advocates of the sanctity of life in this country. Pope Pius XII, addressing a group of physicians in 1957, remarked that Christian ethics do not require the administration of extraordinary treatment to patients where life is ebbing hopelessly.[343] The Pope indicated that this statement referred to terminating extraordinary procedures already begun as well as refusing those not yet undertaken.[344]

Recent case law has provided two rationales for permitting the refusal of ordinary medical treatment by patients in a terminal condition, despite the states' interest in preserving the sanctity of life. In *Erickson v. Dilgard*,[345] the court refused to equate the patient's decision to reject a blood transfusion with

339 *Id.* at 422, 201 A.2d at 537.
340 *Id.* at 423, 201 A.2d at 538.
341 *See* Furman v. Georgia, 408 U.S. 238, 286 (1972) (Brennan, J., concurring).
342 The law generally looks upon attempts to terminate life prematurely as the work of an unsound mind and permits the states to interfere to prevent such acts and to punish those who aid in such undertakings, 1 C. TIEDEMAN, TREATISE ON STATE AND FEDERAL CONTROL OF PERSONS AND PROPERTY IN THE UNITED STATES. § 23, at 23 (1900). The problems inherent in ascertaining, after the fact, the decedent's competency to choose death appear to provide a compelling state interest in preventing terminal patients from employing active means to induce death, with or without the assistance of another. Likewise, the states have a compelling interest in safeguarding the lives of terminal patients who decide against a premature death. The difficuties in establishing after the fact that the deceased consented to the application of death-producing measures seem to require that the state prohibit all voluntary mercy-killings, lest outright murder pass unpunished as requested homicide, *id.* at 24. Proposed legislation has sought to negate the basis for such compelling state interests by providing procedures for ascertaining, before active, death-producing means are applied, that the victim is competent to choose death and that he consents to life-terminating treatment, *e.g.*, L.B. 135, 52d Sess., Neb. Legislature (1937).
343 N.Y. Times, Nov. 25, 1957, at 1, col. 3.
344 *Id.*
345 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).

suicide, thereby preventing the state from overcoming the refusing person's will. Stating that it is always a question of judgment whether a medical decision is correct, the opinion supported the right of the patient to make that decision as essential in a system of government dedicated to protecting the individual in furthering his wishes.[346] The New York court, therefore, emphasized the element of unpredictability inherent in medical judgments to show that the patient was not himself disregarding the sanctity of life but entrusting his fate to the forces of nature. The interest of the state in preserving the sanctity of life, of course, extends only to staying individuals from taking the life decision into their own hands. Two other cases, *In re Estate of Brooks*[347] and *Palm Springs General Hospital, Inc. v. Martinez*,[348] present a more direct challenge to that compelling state interest. Both decisions, involving elderly persons near death wishing to refuse ordinary treatment, essentially hold that the sanctity of life is not seriously endangered when dying patients chose a peaceful death over a prolonged life of physical pain and mental anguish. The Florida Circuit Court, vigorously advocating this position in *Martinez*, explained:

> Based upon the debilitated physical condition of the defendant and the fact that performance of surgery upon her and administration of further blood transfusions would only result in the painful extension of her life for a short period of time, it is not in the interest of justice for this Court of Equity to order that she be kept alive against her will.[349]

Because such choices to refuse treatment do not significantly jeopardize the sanctity of life, the states may not be able to justify invading the patients' right to privacy in order to protect that interest.

Still other cases demonstrate that compelling interests put forth in the blood transfusion and religious belief cases may be overcome by terminal patients asserting the right to refuse treatment or a fundamental constitutional guarantee. In a recent case handed down by the Court of Appeals,[350] a patient asserting free religious exercise rights successfully defeated efforts to obtain a court order requiring a blood transfusion. The court noted that the state's interest in protecting the doctor and hospital from civil liability was absent in this situation because the patient had executed a statement releasing the physician and the institution from such liability.[351] That same case also discussed the interest of the state as *parens patriae* in ordering the transfusion, since the patient had two minor children. Noting that in the event of their parent's death, these children would receive adequate material and filial support from the surviving members of the patient's family, the court rejected any claim to a compelling state interest to prevent minor children from be-

346 *Id.* at 28, 252 N.Y.S.2d at 706.
347 32 Ill.2d 361, N.E.2d 435 (1965).
348 Case No. 71-12678, Cir. Ct. of Dade County, Fla., July 2, 1971.
349 *Id.*
350 In Re Osborne, 294 A.2d 372 (D.C. App. 1972).
351 *Id.* at 373; *see also* In Re Estate of Brooks, 32 Ill.2d 361, 372, 205 N.E.2d 435, 442 (1965).

coming wards of the state sufficient to override the first amendment right.[352]

The state's interest in upholding respect for the doctor's conscience and medical oath rests on the premise that physicians uniformly regard honoring the refusal of treatment by a dying patient as contrary to their professional principles. Evidence available that American physicians do practice "euthanasia by omission" weakens this premise.[353] Likewise, the American Hospital Association's recently issued Patients' Bill of Rights, advocating a right to refuse treatment for all patients fails to support a widespread aversion among doctors toward such refusals.[354] As the relationship between a doctor and a patient is consensual in nature,[355] dying patients wishing to refuse further treatment could respect the consciences of doctors who objected to such action by terminating the doctor-patient relationship and acquiring other physicians whose professional principles comported with the patients' wishes. The interest of the states, therefore, in upholding respect for the conscience and oath of doctors need not be compelling in all cases.

Patients unable to render consent to treatment present the most difficult problem. On the one hand the states have an undeniable interest in protecting the lives of individuals unable to provide for their own well-being.[356] On the other, the comatose or deranged condition of such patients precludes them from asserting their right to refuse treatment. Potential civil liability for doctors and hospitals withholding treatment where patients' preferences cannot be ascertained further complicates this situation. The "living will" proposal may provide a way out of this dilemma.[357] This instrument, executed with formalities comparable to those necessary for a valid will, expresses the intention to refuse treatment and to release medical personnel from all liability should its maker become terminally ill and incapable of intelligently asserting this right.[358] This simple procedure places those patients incapable of rejecting medical means to prolong life on an equal basis with those able to intelligently assert their constitutional right and thereby removes any compelling interests the state might otherwise assert for mandating unwanted treatment.

The Supreme Court has recognized the right to privacy as fundamental and recent case law seems to indicate that this guaranty may afford to dying patients a limited right to die. Although in some cases compelling state interests may override such a right, many terminal patients should be able to enjoy the prerogative to refuse ordinary and extraordinary treatment free of state interference.

D. *Euthanasia Legislation—Death with Dignity or State Execution?*

Efforts to secure legitimate relief for dying patients whose lives have become

352 294 A.2d at 374; *see also* In Re Estate of Brooks, 32 Ill.2d 361, 372-73, 205 N.E.2d 435, 442 (1965).
353 See Levisohn, note 80 *supra.*
354 NEWSWEEK, Jan. 22, 1973, at 77.
355 *See* R. MORRIS & C. MORITZ, *supra* note 137, at 135.
356 *See* Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1007-08 (D.C. Cir. 1964), *rehearing en banc denied,* 331 F.2d 1010 (D.C. Cir. 1964), *cert. denied,* 377 U.S. 978 (1964).
357 See Kutner, *supra* note 103, at 550.
358 *Id.* at 551.

pain-ridden and devoid of meaning has proceeded in the state house as well as the courtroom. Since 1937, state legislatures have pondered various proposals legalizing euthanasia in one form or another, although no such bill to date has been enacted.[359]

For purposes of constitutional analysis, these proposals can be classified into two broad categories, each containing two subcategories. The first contains those bills which would permit premature death for the terminally ill only with the legal consent of those to die. Some bills in this category provide for a right to refuse ". . . unnatural medical or surgical means or procedures calculated to prolong life."[360] Others permit premature death to be directly induced by a physician through the use of drugs.[361] The second encompasses bills which authorize a merciful end to physical suffering, even though the patients cannot give legal consent because of minority or physical and mental disability. Typically these proposals permit certain close relatives or a group of doctors to authorize either a withholding of extraordinary life-sustaining measures[362] or the application of a drug overdose to bring on a premature death.[363]

The right to control one's own body seems to enjoy some constitutional protection as an offshoot of the right to privacy. The states may curtail this right, however, upon demonstrating a compelling state interest for doing so. In fact, the Constitution may require the states to intervene to protect a fundamental right of greater significance.[364] But if the interest justifying state interference ceases to be compelling, the states can and indeed must revise the law to reflect this change. Recent revisions in abortion laws, originally passed to protect women from an operation at one time dangerous but now medically safe, demonstrate such an atrophy of a compelling state interest.[365] Nevertheless, the states may not remove safeguards to fundamental constitutional rights utilizing this rationale, as the states always have a compelling interest in protecting such freedoms.[366]

As noted above, case law appears to recognize a right to refuse extraordinary medical treatment in most cases involving the terminally ill. Those compelling interests requiring courts to force blood transfusions and surgical operations upon patients asserting fundamental rights of lesser significance seldom apply to dying patients seeking relief from physical anguish. Proposals recognizing this right and recommending that it be protected through statutes seem constitutionally unobjectionable. The governmental interest usually involved is preservation of the sanctity of life, and as the policy of the Roman Catholic Church demonstrates, refusing extraordinary treatment presents no threat to that interest.[367] These proposals, in fact, probably lag behind recent case law upholding the right to

359 L.B. 135, 52d Sess., Neb. Legislature (1937).
360 S.B. 715, Wis. Legislature (1971).
361 *See* Voluntary Euthanasia Bill in Morris, *supra* note 213, at 269.
362 H.B. 3184, Fla. Legislature (1970).
363 L.B. 135, 52d Sess., Neb. Legislature (1937).
364 *See* Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (1964), *cert. denied,* 337 U.S. 985 (1964) (right to life of a quickened fetus held pre-eminent over right of mother to refuse transfusion on religious grounds).
365 23 VAND. L. REV. 1346, 1351 notes 34 and 35 (1970).
366 *Accord,* Truax v. Corrigan, 257 U.S. 312, 329-330 (1921).
367 *See* N.Y. Times, Nov. 25, 1957, at 1, col. 3.

refuse treatment. Such cases as *In Re Estate of Brooks*[368] and *Palm Springs General Hospital, Inc. v. Martinez*[369] seem to indicate that the refusal of ordinary procedures by dying patients presents no threat to the sanctity of life significant enough to warrant state intervention.

Proposals going beyond the mere recognition of a right to refuse medical care, however, present more serious constitutional questions. These represent a greater infringement upon the sanctity of life and may, therefore, afford some rationale for prohibiting their enactment. An understanding of the nature of the states' interest in preserving the sanctity of human existence will help in making such a determination.

The states have several reasons for regulating to protect the sanctity of life, but not all may be considered when putting various euthanasia proposals to the constitutional test. American society, with its strong religious heritage, partially bases its respect for human existence upon the belief of many that the life-death decision belongs to God and men should not assume such discretion themselves.[370] As pervasive and strong as this feeling may be, it cannot serve as the foundation for the states' concern in protecting life. The establishment clause of the first amendment prohibits the states from using religious beliefs as the basis for social policies.[371] Analyzing the constitutionality of Sunday closing laws, Justice Frankfurter observed in *McGowan v. Maryland*:[372]

> If the primary end achieved by a form of regulation is the affirmation or promotion of religious doctrine—primary, in the sense that all secular ends which it purportedly serves are derivative from, not wholly independent of, the advancement of religion—the regulation is beyond the power of the state.[373]

Any attacks, then, upon euthanasia legislation as unconstitutionally transgressing personal rights which the states have a significant stake in protecting must point to primarily secular foundations for the states' interest. The states can cite several secular reasons underpinning various prohibitions against taking human life. The American system of law recognizes that the indiscriminate taking of life will result in chaos, making the accomplishment of society's social goals impossible, and, therefore, prohibits homicide to promote social stability.[374] Likewise, assuming that only men of unsound mind prefer the uncertainties of the grave to the certainties of life, states forbid self-destruction as an act of those insane, whose lives the states may intervene to protect.[375] Most significant among the states'

368 32 Ill.2d 361, 205 N.E.2d 435 (1965).
369 Case No. 71-12678, Cir. Ct. of Dade County, Fla., July 2, 1971.
370 Religious views of constituents undoubtedly influence legislators voting on euthanasia bills. For religious attitudes toward euthanasia, see Hassett, *Freedom and Order Before God: A Catholic View*, 31 N.Y.U. L. REV. 1170, 1184 (1956); Ramsey, *Freedom and Responsibility in Medical and Sex Ethics: A Protestant View*, 31 N.Y.U. L. REV. 1189, 1200 (1956); Rackman, *Morality in Medico-Legal Problems: A Jewish View*, 31 N.Y.U. L. REV. 1205, 1212 (1956).
371 *See* Morris, *supra* note 213, at 249-51.
372 366 U.S. 420 (1961).
373 *Id.* at 466 (separate opinion).
374 1 C. TIEDEMAN, *supra* note 342, at 24.
375 *Id.* at 23.

secular interests for preserving the sanctity of earthly existence, however, is the responsibility to uphold the fundamental right to life.

This right to life predates the Constitution, and received recognition in the Declaration of Independence as an "inalienable" freedom.[376] Although the Constitution does not expressly mention it, the fifth[377] and fourteenth[378] amendments contain guarantees against the taking of life without due process of law. This constitutional liberty has traditionally enjoyed a preeminent place among the fundamental freedoms as an early commentator on government control of the person recognized:

> The legal guaranty of the protection of life is the highest possession of man. It constitutes the condition precedent to the enjoyment of all other rights. . . . [S]ince its extinction means the deprivation of all temporal rights . . . the cause or motivation for its destruction must be very urgent, and of the highest consideration, in order to constitute a sufficient justification.[379]

Therefore, American law has established few instances in which the taking of human life is permissible. The Constitution has limited government action extinguishing life to situations in which wrongdoers' lives are forfeited for committing crimes so serious as to be considered capital, rationalizing that by perpetrating such acts the wrongdoers have estranged themselves from society and have foregone their fundamental rights as members thereof.[380] As the Supreme Court's holding in *Furman v. Georgia* demonstrates, however, even this justification has come into serious question.[381] State laws, in turn, have severely circumscribed the situations in which one person may take the life of another. Such homicides are permitted in wartime, justified because the social and legal order underpinning all human rights is threatened.[382] Also state laws permit killing in defense of life or to prevent the commission of a dangerous felony, balancing the lives of evildoers against the immediate danger to the lives of others.[383] Under the American justice system, neither individual nor government may take human life without presenting considerations more significant than the right to life itself.

Contemporary case law reaffirms the fundamental nature of the right to life and its preeminent position among the hierarchy of constitutional values. Courts have ruled unfavorably upon the pleas of plaintiffs to put the right to life of unborn children in their mothers' wombs aside in order to permit the exercise of some other fundamental freedom. In *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*,[384] the New Jersey Supreme Court upheld the granting of a court order requiring a woman in her thirty-second week of pregnancy to have a blood transfusion, despite her protestations on religious grounds. The court

376 Jefferson, *The Declaration of Independence of the American States* (1776).
377 U.S. CONST. amend. V.
378 U. S. CONST. amend. XIV, § 1.
379 1 C. TIEDEMAN, *supra* note 342, at 22.
380 *See* Louisell, *Abortion, The Practice of Medicine and the Due Process of Law*, 16 U.C.L.A. L. REV. 233, 248 (1969); Note, *In Defense of the Right to Live: The Constitutionality of Therapeutic Abortion*, 1 GA. L. REV. 693, 698-99 (1967).
381 408 U.S. 238 (1972).
382 Note, *supra* note 380.
383 *Id.*
384 42 N.J. 421, 201 A.2d 537 (1964), *cert. denied*, 377 U.S. 985 (1964).

clearly asserted that the mother's free exercise rights, though fundamental, were not adequate justification for seriously endangering the life of the quickened fetus.[385] Likewise, cases striking down state abortion statutes as unconstitutionally depriving pregnant women of their right to privacy, such as *Roe v. Wade*[386] and *Doe v. Bolton,*[387] have refused to uphold the preeminence of the privacy right after the early stages of pregnancy. Despite more flexible thinking by the courts on matters of life and death, decisions reflect no trend subordinating the right to life to other fundamental freedoms.

Any euthanasia legislation, therefore, to pass the test of constitutionality must not seriously compromise the states' interests in preserving the sanctity of life. Proposals permitting dying patients to request medical means to induce immediate death appear to have the best chance of receiving constitutional approval. Most of these bills contain procedures for ascertaining whether those seeking a premature end are competent to make that choice[388] and whether the applicants are indeed suffering from a terminal or incurable disease.[389] By doing so, these proposals guarantee that indiscriminate killings will not take place and that those requesting death are not among the incompetent whose lives the states have a responsibility to safeguard. The right to life, however, must not be adversely affected by such legislation. Clearly, since those requesting death wish to surrender that right, their fundamental liberty is not unconstitutionally hampered. But fundamental rights protect more than the individuals in an immediate position to assert them, and the states may not permit persons to forfeit an important freedom if the public welfare is thereby prejudiced.[390] Once again considerations such as providing for minor children, releasing civil and criminal liability, and upholding the conscience and professional oath of doctors enter the picture. Since minor children can seldom be left in worse financial condition by the death of parents whose chances of recovery seem nonexistent and since all proposals release medical personnel from civil and criminal liability for carrying out their patients' wishes,[391] these public interests do not appear prejudiced. Further, none of the proposed bills would require physicians to administer the death stroke against their will, and, therefore, present no threat to the professional principles of doctors.

Suggested legislation legalizing the discontinuation of life-prolonging treat-

385 *Id.* at 423, 201 A.2d at 538.
386 41 U.S.L.W. 4213 (U.S. Jan. 22, 1973).
387 41 U.S.L.W. 4233 (U.S. Jan. 22, 1973).
388 *E.g.,* L.B. 135, 52d Sess., Neb. Legislature (1937). Provisions of this bill relating to competent patients provided for a referee and investigating committee to ascertain whether the applicant for euthanasia possessed the competency to choose a premature death. If the applicant proved incompetent, the bill required application by next of kin. Gurney, *supra* note 43, at 252.
389 *E.g.,* Voluntary Euthanasia Bill in Morris, *supra* note 213, at 267. This bill defines "irremediable condition" and gives the physician in charge the responsibility to determine whether the patient in question comes under the coverage of the statute, *id.* at 267, 270. The physician making this determination is held to a standard of "good faith," *id.* at 268.
390 *See* Wren v. United States, 352 F.2d 617, 618 (10th Cir. 1965), *cert. denied,* 384 U.S. 944 (1966); Redgate v. Boston Redevelopment Authority, 311 F. Supp. 43, 47 (D. Mass. 1969); Cameron v. Local 384, Theatrical Stage Employees, 118 N.J. Eq. 11, 27, 176 A. 692, 700 (1935). *Compare* Johnson v. Sanders 319 F. Supp. 421, 432-33, n.32 (D. Conn. 1970), *aff'd,* 403 U.S. 955 (1971), *with* In Re Estate of Brooks, 32 Ill.2d 361, 374, 205 N.E.2d 435, 442 (1965).
391 *See* H.B. 2614, Fla. Legislature (1972) (committee substitute bill); S.B. 715, Wis. Legislature (1971).

ments to those incapable of refusing them[392] or permitting the use of drugs to induce death among the incompetent, upon the consent of a close relative or group of physicians,[393] stands on less firm constitutional footing. Procedural safeguards incorporated into such bills may preserve the public order, but do not absolve the state from its responsibility to preserve the lives of those unable to provide for themselves. Moreover, those comatose, in their minority, or deranged by drugs or pain cannot, as their more competent counterparts, intelligently surrender their right to life. Advocates of "involuntary euthanasia" proposals argue that the states should not force such persons to forego a "death with dignity" simply because they cannot legally consent to it. Nevertheless, there appears no precedent permitting the deprivation of fundamental rights without the intelligent consent of those affected. More sound, from a constitutional point of view, are bills providing a realistic definition of death, which spell out when resuscitators, kidney machines, and intravenous feeding preserve the form but not the substance of life.[394] Given the inability of the law to determine the true desires of the terminally ill at the crucial moment of decision, it seems probable that courts will favor the right to life and hold such "involuntary euthanasia" legislation unconstitutional.

Proponents of the right to life have an array of constitutional theories with which to attack statutes permitting the death of the incompetent, terminally ill without their consent. In structuring such arguments, however, they must consider that the right to life, as such, is not expressly mentioned in the Constitution and that the fourteenth amendment only guards fundamental freedoms from state interference. This should present no serious obstacle, however, as the right to life should find ample protection as an unenumerated right and the concept of state action encompasses both legislative enactments depriving rights and legislative removal of adequate safeguards for such liberties.

Although the right to life escapes specific constitutional recognition, the fourteenth amendment contains a prohibition against the deprivation of life by the states without due process of law.[395] The due process concept, however, seems to have faded in importance after the decisions of the 1930's striking down social legislation as depriving "liberty" and today many constitutional theorists doubt that this guarantee could extend so far as to protect dying patients from involuntary euthanasia.[396] Due process has sometimes been described as no more than the right to a fair hearing before the law. Justice Black espoused this theory of limited due process in *Ferguson v. Skrupa*:[397]

> The doctrine that . . . due process authorizes the court to hold laws unconstitutional when they believe the legislature has acted unwisely . . . has long since been discarded. We have returned to the original constitu-

392 H.B. 3184, Fla. Legislature (1970).
393 L.B. 135, 52d Sess., Neb. Legislature (1937).
394 *See, e.g.*, KAN. STAT. ANN. § 77-202 (Cum. Supp. 1972).
395 U.S. CONST. amend. XIV, § 1.
396 For a commentary on the decline of substantive due process see Bertelsman, *The Ninth Amendment and Due Process of Law — Toward a Viable Theory of Unenumerated Rights*, 37 U. CIN. L. REV. 777, 781-85 (1968).
397 372 U.S. 726 (1963).

> tional proposition that courts do not substitute their social and economic beliefs for the judgement of legislative bodies. . . .[398]

States could probably provide procedures sufficient to meet procedural due process standards by requiring that incompetent patients be represented by guardians unassociated with the interests of the consenting relatives or physicians at a judicial or administrative hearing before a special board with a limited right to judicial review.[399]

Some commentators, however, have rejected this narrow interpretation of due process. They point to a series of cases, readily distinguishable from such decisions as *Lochner v. New York*,[400] which utilized substantive due process to protect personal freedoms, not specifically mentioned in the Constitution, from state interference.[401] The *Meyer v. Nebraska*[402] opinion, striking down state prohibitions to the teaching of German in the public schools, and *Pierce v. Society of Sisters*,[403] removing state requirements that all schoolchildren attend public institutions, seem to have taken the substantive due process route to uphold the unenumerated right of parents to direct their offsprings' education. Constitutional history does record a marked reluctance to utilize that approach again after the economic liberty decisions, but the overbreadth doctrine, applied in many first amendment cases such as *Baggett v. Bullitt*[404] and *Winters v. New York*,[405] seems to employ a mixture of substantive and procedural due process concepts and, therefore, preserves this approach after its abuse in the economic freedom opinions.[406] The concept of substantive due process appears to again have received independent constitutional recognition as a vehicle for protecting personal, unenumerated liberties in *Griswold v. Connecticut*,[407] in the concurring opinions of Justices Harlan and White.[408] Finally in *Boddie v. Connecticut*,[409] a majority opinion called upon due process to strike down exorbitant court fees and costs in divorce actions, as denying the right of access to the judicial process.[410] The limited definition of due process, occasioned by early decisions wiping out social legislation, appears to be falling from judicial favor, and may not hinder those seeking to use it to challenge "involuntary euthanasia" statutes.

Substantive due process need not be the only recourse for protecting dying patients from state sanctioned, mercy killings. The right to life as an unenumerated freedom may also find recognition under the ninth amendment.[411] The

398 *Id.* at 730.
399 *See* Louisell, *supra* note 380, at 251. The procedural safeguards which Professor Louisell discusses in the abortion context may serve as a guide in determining procedural due process requirements for involuntary euthanasia.
400 198 U.S. 45 (1905).
401 *See* Emerson, *supra* note 299, at 223.
402 262 U.S. 390 (1923).
403 268 U.S. 510 (1925).
404 377 U.S. 360 (1964).
405 333 U.S. 507 (1948).
406 Emerson, *supra* note 299, at 224.
407 381 U.S. 479 (1965).
408 *Id.* at 499, 502.
409 401 U.S. 371 (1971).
410 *See also* note 321 *supra.*
411 For historical development of the ninth amendment see Bertelsman, *supra* note 396, at 780-81; Ringold, *The History of the Enactment of the Ninth Amendment and Its Recent Development,* 8 TULSA L.J. 1-44 (1972).

Griswold decision acknowledged this provision as a sanctuary for those rights too numerous to list in the Bill of Rights, yet so rooted in the traditions and collective conscience of the American people as to be regarded as fundamental.[412] Since *Griswold,* jurists and constitutional scholars alike have struggled to ascertain objective standards by which these fundamental rights might be determined. Those advocated include: 1) recognition of a right as fundamental by a pre-Constitution American source of law;[413] 2) pervasive mention of an unenumerated liberty in the bills of rights of state constitutions;[414] and 3) acknowledgement of a freedom in the *Universal Declaration of Human Rights,* passed by the United Nations General Assembly in 1948.[415] The right to life qualifies for ninth amendment protection under all three standards. Prior to 1789, the Declaration of Independence termed the right to life "inalienable"[416] and the common law permitted its deprivation only in time of war and to prevent the commission of a dangerous felony.[417] Likewise, almost all state constitutions recognized the right to life as inalienable at an early date[418] and continue to do so today.[419] Finally, Article 3 of the *Universal Declaration of Human Rights* states that "everyone has the right to life, liberty, and security of the person."[420] Therefore it appears very possible that the right to life could pass as fundamental under ninth amendment standards. Advocates of "involuntary euthanasia" may assert a compelling state interest in providing "death with dignity" for incompetent, terminal patients overriding this ninth amendment right, but the failure of American law to recognize such an interest where patients cannot make an intelligent choice for death weakens the force of this argument.

Nor does the ninth amendment exhaust the constitutional concepts available to attack this suspect legislation. Such statutes, in effect, would single out the incompetent, terminally ill for no protection against the taking of life by another while healthy citizens would continue to enjoy the full protection of homicide laws. Since state action may encompass legislation encouraging the acts of private citizens as well as statutes mandating government conduct,[421] these enact-

412 381 U.S. 479, 487 (1965) (Goldberg, J. concurring).
413 Ringold, *supra* note 411, at 27-28.
414 *Id.* at 34.
415 *Id.* at 33-34.
416 Jefferson, *The Declaration of Independence of the American States* (1776).
417 *See* Louisell, *supra* note 380, at 247.
418 *See* 1 C. TIEDEMAN, *supra* note 342 § 3, at 15.
419 *E.g.,* CAL. CONST. art. 1, § 1; FLA. CONST. art. 1, § 2; ILL. CONST. art. 1, § 1; MASS. CONST. art. 1, § 2; PA. CONST. art. 1, § 1.
420 Although commentators have pointed to the *Universal Declaration* as merely a guide for American constitutional development in the area of unenumerated rights, a foundation may exist for looking to that document as a source of American law. A California court in *Sei Fujii v. State,* 417 P.2d 481 (Cal. App. 1950), *rehearing denied,* 418 P.2d 595 (Cal. App. 1950), used the *Universal Declaration* as a basis for interpreting the *United Nations Charter* as prohibiting enforcement of the alien land law of that state. The California Supreme Court later rejected this argument, declaring that the *United Nations Charter* is not a self-executing treaty and cannot, without enabling federal legislation, preempt the operation of a state law, *Sei Fujii v. State,* 38 Cal. 2d 718, 721-25, 242 P.2d 617, 620-22 (1952). Nevertheless, the California Supreme Court did not challenge the manner in which the lower court used the *Universal Declaration. See generally* Wright, *National Courts and Human Rights — The Fujii Case,* 45 AM. J. INT'L LAW 62 (1951). Most nations voting for the *Universal Declaration* in the General Assembly do not recognize it today as legally binding standing alone. J. CASTAÑEDA, LEGAL EFFECTS OF UNITED NATIONS RESOLUTIONS 193-95 (1969).
421 Vanderbilt v. Hegeman, 157 Misc. 908, 911, 284 N.Y.S. 586, 590 (1935).

ments may well constitute state action denying terminal patients unable to consent to death equal protection of law.[422] The question of a compelling state interest justifying different treatment for involuntary euthanasia victims becomes pertinent, but the courts' probable response to such an argument should be essentially the same as when considered in light of due process and ninth amendment objections.

American law has long acknowledged the preeminence of the right to life and, through the process of case law evolution, has but vaguely recognized a right to choose death. Legislation, however, embodying adequate procedural safeguards, could remove many of the constitutional objections for affording dying patients that discretion. Nevertheless, statutes permitting the imposition of death upon the terminally ill unable to request to die remain suspect, and may not pass the scrutiny of a system of judicial review prone to err on the side of fundamental freedoms.

V. Legislation

A. *Initial Attempts to Draft Legislation*

The stirrings of legislative thinking crystallized in the formation of the English Euthanasia Society in 1932. With mixed public support concerning the scope of euthanasia legislation, the Society proposed a voluntary euthanasia act in 1936 and 1937.[423] The act has become the prototype for subsequent legislation in England and the United States. The mainstay of this early act is the rather simple but legally essential notion that death by euthanasia should not be deemed an unnatural death. Implicit in this notion is a view of life from a qualitative perspective rather than in absolute terms of mere existence.[424] Under the latter view the law could not distinguish the existence of a robust individual from the existence of an individual tormented by an incurable illness.

The English act was restricted to consensual euthanasia by competent adults.[425] The patient would execute a certificate of intent stating his desire for an advanced death if he should suffer from a terminal illness. This certificate of intent which has been included in all proposed legislation was in 1936, and continues today, to be the crux of the debate over whether any viable euthanasia legislation can be drafted. The critics assault this approach by pointing to the

422 *See* Reitman v. Mulkey, 387 U.S. 369, 375 (1967); Truax v. Corrigan, 257 U.S. 312, 329-30 (1921).

423 182 LAW TIMES 412 (1936). Lord Ponsonley's bill required the patient to execute a statement that he exceeded twenty-one years of age, that he was suffering from an incurable and terminal illness and that this statement was signed in the presence of two witnesses. Submitted with the patient's statement are two medical certifications of the patient's illness. An official appointed by the Minister of Health, a "Euthanasia Referee," would determine the capacity of the patient to consent and would verify the medical determination. The patient's statement, the medical certificates and the referee's certificate would be evaluated by a court empowered to issue a certificate authorizing the administration of euthanasia. *See also* YOUR DEATH WARRANT? (J. GOULD ed. 1971); G. WILLIAMS, *supra* note 47.

424 *See generally* D. MEYERS, *supra* note 59, at 140. Joseph Fletcher, an Episcopal moral theologian, has introduced into the euthanasia discussion the concept of qualitative existence as opposed to viewing life in absolute terms. *See also* Fletcher, *Legal Aspects of Decision Not to Prolong Life*, 203 J.A.M.A. 65 (1968).

425 *Supra* note 423.

inadequate safeguards that such a certificate provides.[426] They contend that it is inadequate to establish competent consent and fails to protect the individual should he execute a later revocation of that consent. This criticism is rather myopic. The certificate of intent is only evidence of consent to be considered with other relevant circumstances by the quasi-judicial machinery which each bill creates. This machinery may take the form of a "referee"[427] or "hospital committee."[428] However, a superior approach is to void any such certificate if the patient becomes unconscious or incompetent prior to the time the request is considered.

Despite the avid support of the Society, the Church of England,[429] together with the critics of the legislation, defeated the proposal.[430]

With the formation of the American Euthanasia Society in 1938, a new dimension was added in the advocacy of limited, involuntary euthanasia.[431] The American proposal was substantially similar to its English counterpart except for its provision for involuntary euthanasia of monstrosities and imbeciles. No doubt the opinion was offered that such limited "mercy-killing" was surreptitiously performed in hospitals and homes. However, the proposal was too startling for a child-centered society with an almost defined folklore speaking of its protection of the helpless.

The first bill to be introduced in the United States was in Nebraska.[432] The bill was patterned after the 1936 English act. It required application by a patient accompanied with a medical certification of the patient's condition by the attendant physician. These would be weighed by a judge acting as a referee. The Nebraska bill differed, however, by allowing application to be made by another in behalf of a minor or mentally incompetent adult. Such an application would be acted on as if submitted under ordinary circumstances requiring medical certification and review by the court. In this bill, unlike any prior or subsequent bill, the illness need not be fatal. In the same year, a similar bill was introduced in the New York legislature but without the involuntary euthanasia provisions. Neither bill was enacted.[433]

B. *Recent Legislative Proposals*

No further serious attempts to enact legislation occurred until the Voluntary Euthanasia Act of 1969 was introduced in the House of Lords. This proposal, however, failed to be given a second reading.[434] This later English bill departed

426 J. GOULD, *supra* note 423, at 73.
427 Gurney, *supra* note 43, at 252.
428 Kutner, *supra* note 103, at 551.
429 *See* G. WILLIAMS, *supra* note 47, at 333.
430 There were no further attempts to introduce a bill into the House of Lords until 1968. Lord Chorley was unsuccessful in 1950 in his motion to inquire into voluntary euthanasia. *See Parliamentary Debates,* vol. 109, col. 552 (November 1950).
431 Gurney, supra note 43, at 237.
432 L. B. 135, 52d Sess., Neb. Legislature (1937). *See generally* J. GOULD, *supra* note 423, at 30.
433 *See generally* G. WILLIAMS, *supra* note 47, at 331. Williams alludes to the popularity of euthanasia legislation by reference to a survey taken among the medical community in 1938. Of 3,272 physicians who replied to a questionnaire, 80 per cent favored euthanasia.
434 Gould, *supra* note 423, at 32.

from prior legislative thinking which had advocated active steps to advance the death of the patient. The 1969 bill limited the discretion of the physician to a termination of steps to prolong life. Thus the proposal was rather behind developing case law in this country. In *Erickson v. Dilgard,*[435] a New York court upheld the patient's right to refuse a blood transfusion. The court was not impressed with the argument that this would, in effect, be the taking of life in violation of the state penal code. The Illinois Supreme Court in *In Re Estate of Brooks*[436] held that the ordering of a blood transfusion in spite of religious objections violated the first amendment. Similarly, in *Palm Springs General Hospital, Inc. v. Martinez,*[437] the Florida Court held that a seventy-two-year-old woman could refuse an operation to correct a condition of collapsed veins which prevented the use of a blood transfusion. The court held that such a refusal is permissible even when the best medical opinion deems it essential to save her life.[438] In these few cases may be seen the beginnings of a recognition that a competent adult may refuse ordinary means of preserving his life. This implication is a patent departure from prevalent judicial thinking which restricts the right of refusal to extraordinary or artificial treatment such as used to sustain the life of a comatose patient with irreparable brain damage.[439]

The Act of 1969 employed an advance declaration of intent—a certificate of intent executed in anticipation of an "irremediable condition."[440] This certificate serves a probative function in the establishment of the patient's consent to euthanasia. Such a consent becomes operative upon the occurrence of prescribed medical conditions set forth in the writing. Procedurally, this proposal for advanced consent avoids the awkard and distasteful formalities of consent verification found in preceding legislation. It also eliminates those unreliable consents given when the patient's mental faculties are usually distorted by pain and drugs. The act, however, failed to adequately provide for implementing this advance declaration.[441] Consequently, it was defeated by fears of insufficient safeguards concerning the capacity of the patient and the revocability of the consent.

The shortcomings of the advance declaration of intent in the 1969 act should not overshadow the pragmatic utility of such a proposal for future legislation. One alternative is to draft the declaration of intent clause within the guidelines of Luis Kutner's proposed "living will."[442] His suggestion is superior because it combines an advanced declaration with adequate safeguards. Ideally, Kutner's document would be executed prior to any illness. This would avoid the influence

435 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).
436 32 Ill.2d 361, 205 N.E.2d 435 (1965).
437 Case No. 71-12678, Cir. Ct. of Dade County, Fla., July 2, 1971.
438 *Id.*
439 *See, e.g.,* Application of President & Directors of Georgetown Col., 331 F.2d 1000 (D.C. Cir. 1964), *rehearing en banc denied,* 331 F.2d 1010 (D.C. Cir. 1964), *cert. denied,* 377 U.S. 978 (1964). The court ordered a blood transfusion to save the patient's life. *See generally* J. WALTZ and F. INBAU, *supra* note 139, at 168. The authors state, citing *Application of President & Directors of Georgetown College,* as authority, that in an emergency a physician can treat a patient despite his adamant refusal to consent.
440 *See generally* J. GOULD, *supra* note 423, at 107 *et seq.* The chapter contains an analysis of the 1969 Act although the author allows his opposition to euthanasia legislation to prejudice his writing on certain points.
441 *Id.* at 115.
442 Kutner, *supra* note 103, at 539.

that pain and the prospect of financial damage to the family may have on the patient's decision. Kutner's procedure is more cumbersome than prior legislation with respect to bureaucratic steps required for determining the patient's intent and the requirement that the declaration be notarized and attested to by witnesses. The "living will" is not as determinative of the existence of consent as was the declaration of intent in the Act of 1969. A "living will" would be evaluated by a committee as circumstantial evidence supporting the existence of consent. In summary, Kutner's proposal, while involving a slower process than the 1969 Act, avoids the weaknesses of former legislation by insuring the establishment of consent. It removes the criticism that consent to euthanasia is not a rational decision but a decision engendered by sickness.

In 1970 euthanasia legislation was introduced in Florida[443] and Wisconsin.[444] The provisions of these proposed bills are in accord with the Euthanasia Act of 1969. They both employ an advance declaration of intent. Interestingly, however, the American proposals are limited to the refusal of extraordinary treatment.[445] This is a dramatic shift in American thinking which forty years prior advocated not only active means to effect euthanasia but also involuntary "mercy-killing." These bills together with their modern English counterpart represent a more conciliatory approach to this emotive issue.

A rather curious aspect of the American legislation is its limitation to the cessation of extraordinary or artificial means of sustaining life. In this respect these proposals do little more than codify present case law. Therefore the trend of decisions permitting the refusal of ordinary treatment makes these proposals superfluous.[446] However, such legislation does provide some security to the physician who is confronted by a patient's or spouse's refusal to continue extraordinary treatment. Yet, it is redundant to propose legislation to permit what is concededly legally permissible.[447]

The Florida proposal has been validly criticized for its sketchy drafting.[448] The act declares that one has an inalienable right to die with dignity, but there is no attempt to explain the scope of this right. The bill further states that life, if one so elects, "shall not be prolonged beyond the point of a meaningful existence."[449] Again, the bill lacks definitiveness. Meaningful existence has too many connotations to be an effective limitation on the performance of euthanasia. The proponents, however, interpret "beyond meaningful existence"[450] to mean the point at which life can only be sustained by extraordinary means. As discussed above, this is no advance over present law except for the statutory grant of immunity to physicians who administer euthanasia by ceasing extraordinary or artificial treatment.[451] Even here, however, this proposal fails since case law

443 H. B. 3184, Fla. Legislature (1970).
444 S. B. 670, S. B. 715, Wis. Legislature (1971).
445 Note, *Death With Dignity: A Recommendation For Statutory Change*, 22 U. FLA. L. REV. 368, 374 (1970).
446 *See, e.g.*, Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).
447 *Contra, supra* note 445.
448 Memorandum from Thomas A. Horkan, Jr., to members of the Health and Rehabilitative Services Committee, circulated by the Florida Catholic Conference, March 29, 1971.
449 H. B. 2914, Fla. Legislature (1971).
450 *Id.*
451 *But see* Fletcher, *supra* note 424, at 67.

obviates the necessity for legislative attempts at such exoneration.[452]

Finally, the Florida proposal does not specify or limit those persons who may administer euthanasia. Whether the draftsmen implied that only physicians may stop the treatments cannot be discerned from the text of the bill. Regrettably, this again points to the cursory drafting of the act.

The Wisconsin bills[453] are substantially similar to the Florida act but the limitation to cessation of extraordinary or artificial means is more explicit. One of the Wisconsin acts[454] follows the Florida proposal by permitting consent to be given by another if the patient is mentally incompetent. This bill differs, however, by including minors within this provision while the Florida act is restricted to adults. Even though the Wisconsin bill and, to some extent, the Florida bill would allow limited involuntary euthanasia, they do not exceed the permissible limits established by case law for the cessation of extraordinary treatment.

C. *Future Legislative Proposals*

With respect to the social acceptability of future euthanasia proposals, public reaction, whether caused by the alarmism of certain religious sects or the naiveté of the public with respect to medical realities, evidences a shrinking from a serious discussion of the problem of euthanasia.[455] Any proposed legislation advocating active or involuntary euthanasia would be fruitless. A more viable and conciliatory approach, such as the Florida bill, could, with proper drafting and discussion, allay the groundless fears and permit serious legislative consideration. A favorable public opinion to a limited euthanasia proposal is reflected in the recent case developments of the right to refuse medical treatments. Cases such as *Erickson v. Delgard* and *In Re Osborne*[456] suggest that future legislation should include the refusal of ordinary means of sustaining life. However, if the draftsmen follow the more limited approach of *John F. Kennedy Memorial Hospital v. Heston*[457] and only permit a refusal of extraordinary treatment, the proposal should adequately differentiate ordinary from extraordinary treatment. With the recent interest in the ninth amendment piqued by *Griswold v. Connecticut*,[458] social acceptance to limited euthanasia appears to exist.

In drafting new proposals, the major objective should be to provide for an informed consent by a capable, lucid patient. The advanced declaration of intent in the English Act of 1969 should be used in future proposals as a method of safeguarding consent. As suggested, implementing Luis Kutner's "living will" even though procedurally cumbersome would enhance the effectiveness of an advanced declaration of intent.

The next drafting aspect is the inadequacy or absence of term definitions within the proposed legislation. A proposal so socially sensitive must be drafted

452 *See, e.g.*, note 82E *supra*.
453 S. B. 670, S. B. 715, Wis. Legislature (1971).
454 S. B. 670, Wis. Legislature (1971).
455 *See* Morris, *supra* note 213, at 244.
456 294 A.2d 372 (D.C. App. 1972).
457 58 N.J. 576, 279 A.2d 670 (1971).
458 381 U.S. 479 (1965).

in detail with no reliance on implication. Provisions for consent, limits on refusal of treatment, capacity to consent, revocation, protection of physicians and medical technicians, insurance policies and authorization of euthanasia must be fully and reasonably described and defined.

D. *In Search of a Statute*

Proposed euthanasia legislation in recent years has attempted to codify case law dealing with the right to refuse medical treatment. There has been an abandonment of earlier legislative themes of active and involuntary euthanasia. In the United States the Florida and Wisconsin bills provided for the refusal of extraordinary means of sustaining the patient's life. The dilemma in drafting such proposals is that case law has yielded little consistency in defining the scope of this refusal and the nature of extraordinary treatment. A survey of cases concerning the refusal of blood transfusions leads to the conclusion that one can refuse only artificial or extraordinary treatment. The recent trend, on the other hand, defines a right to refuse treatment encompassing ordinary medical treatment as exemplified by *Erickson v. Dilgard.* However, case law has failed to deal adequately with the "hard" case. This is exemplified by *Application of President & Directors of Georgetown College*[459] which considered the right to refuse treatment in the light of the social and legal considerations generated by the presence of the patient's minor children and the potential liability of those who acquiesce in the patient's refusal of treatment. A brief examination of the significant case law will reveal the necessity for legislation to distinguish the legally permissible, passive submission to death from the compelling state interest in sustaining life.[460]

In the *Georgetown College* case, a Jehovah's Witness refused a blood transfusion on religious grounds but agreed to submit to treatment if the court so ordered. The court avoided the religious issue by stressing three factors. First, the court pointed to the responsibility of the woman to her minor child. Next, the court concluded that the woman was expressing a desire to live by submitting herself to the hospital's care. Lastly, the court noted that a refusal to order the transfusion would expose the hospital and its staff to liability. The flaw in the court's reasoning appears in its failure to recognize that although the woman submitted to treatment, she expressly refused a transfusion. It is possible to desire to live yet subordinate that desire to religious convictions. The court also failed to consider the fact that releases were given to the hospital and its staff. The only factor not in contention is the woman's duty to her minor child. If this is the determining factor of the case, then this decision can be explained as an extension of the protection given to an unborn whose mother refuses a transfusion.[461] Therefore, the case is of questionable precedential value in limiting

459 331 F.2d 1000, *rehearing en banc denied,* 331 F.2d 1010 (D.C. Cir. 1964), *cert. denied,* 377 U.S. 978 (1964).

460 *See, e.g.,* John F. Kennedy Memorial Hospital v. Heston, 58 N.J. 576, 581, 279 A.2d 670, 672 (1971).

461 State v. Perricone, 37 N.J. 463, 181 A.2d 751, *cert. denied,* 371 U.S. 890 (1962).

the refusal of medical treatment to extraordinary means. Notwithstanding the above, this case is repeatedly cited in support of such a limitation on refusal.

Interestingly, this case which serves as a precedent for limiting refusal to extraordinary means was never explicitly ruled on by a majority of the appeals court. The order was granted by a circuit judge upon oral petition. A petition for rehearing *en banc* was denied without the court stating whether the majority concurred with Judge Wright's action or considered the case moot. Circuit Judge Miller was of the opinion[462] that the case was nonjudiciable since, procedurally, the issue was never presented to the court. In light of Judge Miller's opinion the validity and value of such a precedent can be questioned.

In *John F. Kennedy Memorial Hospital v. Heston,* the court ordered the transfusion of an unmarried woman, a Jehovah's Witness, who, for religious reasons, refused the blood transfusion. The court based its decision on a compelling state interest in sustaining life and avoiding liability of the hospital due to its acquiescence in the refusal.

The court's development of the state's interest in sustaining life is based on a rather sweeping conclusion that there is no difference between suicide and passive submission to death. Legally, if not morally, it is difficult to construe a woman's desire to refuse a blood transfusion on religious convictions as suicide. However, *Heston,* through its employment of a compelling state argument, is more cogent than the *Georgetown College* case. Further, as in *Georgetown College, Heston* does not deal with first amendment infringement which, as will be seen, figured so significantly in *In Re Brooks.*

Erickson v. Dilgard is the most emphatic decision supporting the right to refuse medical treatment. The *Erickson* court held that ". . . it is the individual who is the subject of a medical decision who has the final say. . . ."[463] Without any elaboration of its rationale *Erickson* unqualifiedly extended the right to refuse treatment. That the *Erickson* court, if presented with the fact pattern in *Georgetown College,* would limit its holding is not above dispute. Where minor children or other complicating factors are present, a physician whose patient refuses ordinary means of sustaining life must decide whether or not *Erickson* warrants that refusal.

Except for an absence of a religious motivation for refusing treatment, *Erickson* is factually similar to *Heston* yet diametrically opposed in its holding. One may speculate that the difference is in the initial premise of *Heston* that suicide and passive submission to death are identical. Therefore, the liability of an individual for administering treatment to sustain life or the failure to do so may rest on the unfettered discretion a court has in classifying a patient's refusal to submit to treatment. There should be a decision as to whether such a refusal is suicide or a decision within the individual's discretion. Case law has not provided the answer.

In *In Re Estate of Brooks,* the Illinois Supreme Court ruled that a blood transfusion over a religious objection violated the first amendment. While in

462 Application of President & Directors of Georgetown Col., 331 F.2d 1010, 1011 (D.C. Cir. 1964).
463 44 Misc. 2d 27, 28, 252 N.Y.S.2d 705, 706 (1962).

In Re Osborne the court appears to have limited the scope of the earlier *Georgetown College* decision. Although there were children, the patient had adequately provided for them which is a circumstance absent in *Georgetown College*. It would appear that the state's interest was outweighed by the patient's religious objection to a blood transfusion.

The confusion of the case law in the area of refusal of treatment underscores the need for legislation. The courts have not adequately clarified the discretion that an individual has over his life. Any attempt to reconcile the cases would be in vain. The only viable alternative is legislation. No longer are reproaches to euthanasia legislation based on alarmism and religious grounds sufficient to outweigh the need for consistency in the law. Norman St. John-Stevas argues the wedge theory and the Nazi experience with genocide as reasons for opposing euthanasia legislation.[464] The wedge theory can be used to discredit a proposal by stressing the most reprehensible purpose for which the proposal could be employed. As a tactic it can be applied to make any legislation appear abhorrent. The issues of proposed legislation are the objectives sought to be attained. The possibility of absurd results confuses intelligent discussion with emotion. Similarly, the Nazi experience of genocide existed in a social atmosphere which rationally cannot be analogized to any other period of time.[465]

Suggestions such as Glanville Williams' which maintain that there is no necessity for legislation are myopic.[466] Williams prefers to grant immunity to physicians who administer euthanasia in good faith.[467] Such an alternative to legislation is not within a reasonable man's expectation that the law should be lucid and consistently applied. Merely suggesting that a physician should be presumptively immune for administering euthanasia only deals with one facet of the problem. The implications of euthanasia are broader than the physician's liability.

Arval Morris cogently observes that the failure of legislative enactments is a result of a confusion of social and medical considerations with religion.[468] Religious grounds, he argues, are constitutionally irrelevant and a legislator shirks his duty in permitting religious considerations to defeat permissible legislation.[469] Morris refers to Mr. Justice Frankfurter's opinion in *McGowan v. Maryland*[470] and states:

> This confusion is peculiarly inappropriate and tragic in America where our Constitution has intentionally isolated religious affairs from secular affairs by constructing a high wall of separation between church and state. Under our Constitution a state is disabled from legislating on religion or on religious grounds. . . . These limitations are part of a legislator's constitutional duties. . . . [I]f, by breach of a legislator's duty, religious grounds are allowed to

464 N. St. John-Stevas, The Right to Life 36 *et seq.* (1964).
465 Kutner, *supra* note 103, at 546.
466 G. Williams, *supra* note 47, at 340.
467 *Id.* at 341; *contra,* Kamisar, *supra* note 2, at 988. Kamisar criticizes Williams' approach since it allows the physician too much discretion.
468 Morris, *supra* note 213, at 249.
469 *Id.*
470 366 U.S. 420, 459 (1961) (separate opinion).

> defeat an otherwise permissible proposed statute, the result is simply an absence of legislation which is not a legitimate subject for judicial review or redress.
>
> The basic point is that religious grounds are constitutionally irrelevant. . . .[471]

There is a necessity for replacing our neurotic attitudes toward death and viewing death as a biological function.[472] It is only in that context that the merits of euthanasia legislation can be clearly and objectively perceived.

William H. Baughman
John C. Bruha
Francis J. Gould

471 Morris, *supra* note 213, at 248-49.
472 Morris, *supra* note 213, at 244.