

A Review of the Right to Die for Terminally Ill Patients

Bernard K. Freamon*

Linda Mehling**†

In 1971, a unanimous New Jersey Supreme Court declared; "[T]here is no constitutional right to choose to die."¹ Less than five years later, however, the same court held that such a right indeed exists, and although it is not absolute in every case, it is entitled to constitutional protection and can be exercised on behalf of an unconscious or otherwise incompetent patient.²

The New Jersey experience illustrates the dramatic changes this area of law has undergone in the last several years, a reflection in part of two recent developments in the practice of medicine — the increasing availability of advanced, life-prolonging medical technology and a concomitant shift away from the individual doctor-patient relationship. In many modern hospitals, treatment decisions no longer are made by an individual treating physician. Rather, the patient finds himself in a "system" of treatment by indistinguishable, ever-shifting teams of medical personnel, each with its own sub-divided function, so that no single doctor determines the appropriate or rational overall course of treatment.³ Thus, the opportunity for an empathic doctor-patient relation-

* Associate Professor of Law, Seton Hall University School of Law. B.A., Wesleyan University, 1970; J.D., Rutgers University School of Law (Newark), 1974.

** Member of the New Jersey Bar. B.A., City University of New York, 1974; J.D., Rutgers University School of Law (Newark), 1978.

† The authors gratefully acknowledge the invaluable assistance of Louis Masucci, Jr., J.D., Seton Hall University School of Law, 1981; Stephen Cahir, J.D., Seton Hall University School of Law, 1982; John Donnelly, J.D., Seton Hall University School of Law, 1983; and the thoughtful suggestions of Alice V. Mehling, Executive Director of the Society for the Right to Die, New York.

1. *J.F.K. Memorial Hospital v. Heston*, 58 N.J. 576, 580, 279 A.2d 670, 672 (1971).

2. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1975), *cert. denied*, 429 U.S. 922 (1976).

This article examines the current state of the law regarding the treatment of terminally ill patients. "Terminal illness," as the term is used in this article, refers to a condition or disease from which there is no reasonable prospect of recovery. This usually means that death is imminent, but also includes the condition in which a patient remains clinically alive for an indefinite time in a comatose state from which there is no reasonable prospect of recovery.

Similarly, the terms "life-prolonging" and "life-saving" are distinguishable, the prolongation of life generally referring to a brief extension of the dying process as opposed to the attainment of recovery or remission. Beyond the scope of this article, therefore, is an examination of the right of non-terminally ill patients to decline life-saving treatment.

3. A disturbing article regarding this phenomenon, authored by a physician whose terminally ill mother had begged him to ensure that her death would not be prolonged unnecessarily.

Right to Die

ship is diminished and, with it, the long-standing medical tradition to "distinguish between curing the ill and comforting and easing the dying."⁴ In such situations, conditions like cardiac arrest often automatically invoke the same response—resuscitation—no matter how terminal the patient.

As a result, courts and lawmakers face a new medico-legal dilemma—one fraught with ethical and religious implications. Does a failure to prolong the existence of any life, eventually result in a diminution of the value of all life? On the other hand, as one court posed the question: "Is there a moral justification in using therapeutic means to delay certain death and thereby prolong the emotional stress of a family and maintain a condition which may be far worse than death?"⁵

Significantly, perhaps surprisingly to some, judicial response to this fundamental conflict of views has been remarkably uniform. With a single exception,⁶ major court decisions of the past five years, including decisions by the highest courts of New Jersey, Massachusetts, Delaware and Florida, have upheld the right of a terminally ill patient to refuse life-prolonging treatment.⁷

From the perspective of the legal representative[s] of a hopelessly ill patient who seeks to terminate treatment, crucial problems remain. The true test of the strength of a constitutional guarantee, after all, is whether it is recognized and respected such that litigation to enforce it is unnecessary. A right that cannot be exercised except through time-consuming, costly court proceedings remains chimeric for many terminally ill patients.⁸

rily, refers to hospital personnel as the "impersonal horde—residents, interns, registered nurses, licensed practical nurses, student nurses, nurse's aides, takers of blood pressures, takers of temperature, cleaners of the floor, cleaners of the woodwork above the floor, orderlies, technicians . . ." He describes his frustrating efforts to locate and meet with the attending physician to discuss the course of his mother's treatment. At last he achieves a meeting in which he explains her wish not to be kept alive under such circumstances. "The attending physician listened sympathetically, understood fully, and agreed completely, but *nothing changed*. He who should have been in control of the system was dominated by it." Netsky, *Dying in a System of "Good Care": Case Report and Analysis*, 39 THE PHAROS 57 (April 1976).

4. *In re Quinlan*, 70 N.J. at 47, 355 A.2d at 667.

5. *Dockery v. Dockery*, No. 51439, at 9 (Tenn. Ch. App.), *aff'd*, 559 S.W. 2d 952 (1977).

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

7. *See, e.g.*, *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1978) (chemotherapy denied to severely retarded man suffering from fatal leukemia); *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1981) (removal of respirator support from comatose woman); *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So. 2d 359 (Fla. 1980) (removal of respirator support from competent man with amyotrophic lateral sclerosis).

8. *See, e.g.*, *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So. 2d 359 (Fla. 1980). Unable to exercise his right to decide the course of his own treatment, Perlmutter finally sought a court order restraining the hospital and treating personnel from interfering with his decision to discontinue use of the respirator. The trial court authorized the removal of the respirator but

Why, despite the near unanimity with which courts in the past several years have upheld a patient's right to refuse life-prolonging treatment, do we continue to see so many unnecessary and protracted legal proceedings in this area?⁹ Having resolved the first crucial question—is there a right to die?—in the affirmative, courts and lawmakers are grappling with the next issue—the sensitive and complex problem of establishing procedures that adequately maintain the delicate balance between guaranteeing a patient's right to decline treatment and ensuring that treatment will be afforded the patient who desires that all life-sustaining measures be used. Indeed, some courts have questioned whether they have the authority to act in this area in the absence of legislation.¹⁰ In response to this need, thirteen states and the District of Columbia have enacted legislation and bills are pending in several others.¹¹ Such legislation clarifies the right of the terminally ill patient to refuse treatment and sets forth guidelines for physicians regarding the termination of life-support systems. They utilize the "living will"—an advance declaration of an individual's wishes with regard to treatment in the event she/he is incapable of expressing them at the time the treatment decision must be made.¹²

This article begins with an analysis of the two legal principles that provide the doctrinal foundation for a patient's right to decline life-prolonging treatment—the common law informed consent doctrine and the constitutional right to privacy. Next, the complex issues raised by the

the matter was appealed by the State to the District Court of Appeals, which affirmed and, in view of the "exigencies of [the] situation," declined to certify the matter for review by the Florida Supreme Court. Nonetheless, the State did apply for such review. Perlmutter died during the Supreme Court proceedings. The Florida Supreme Court, on January 17, 1980, adopted the opinion of the District Court of Appeals.

9. See, e.g., *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E. 2d 134 (1978) (do-not-resuscitate order obtained for incompetent, terminally ill patient); *In re Spring*, 1979 Mass. App. Adv. Sh. 2469, 399 N.E. 2d 493, *rev'd* 405 N.E. 2d 115 (Mass. 1980) (discontinuance of hemodialysis for incompetent patient); *Eichner v. Dillon*, 73 A.D. 2d 431, 451, 426 N.Y.S. 2d 517, 533 (App. Div. 1980), *modified*, 52 N.Y. 2d 363, 420 N.E. 2d 64, 438 N.Y.S. 2d 266 (1981) (removal of respirator support from comatose patient). In each of these cases, the trial court ruled in favor of terminating treatment, yet the patients were subjected to further suffering and expense because appeals were taken. In each case, the trial court's decision in favor of the patient was ultimately upheld.

10. See, e.g., *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1345-1349, (Del. 1980); *Eichner v. Dillon*, 73 A.D. 2d 431, 451, 426 N.Y.S. 2d 517, 533-536 (App. Div. 1980), *modified*, 52 N.Y. 2d 363, 420 N.E. 2d 64, 438 N.Y.S. 2d 266 (1981).

11. Hereinafter, the "thirteen states and the District of Columbia" will be referred to as the "fourteen jurisdictions" which have enacted living will statutes. See note 148, *infra*.

12. Living wills and implementing legislation are designed, in part, to reduce the number of situations in which someone other than the patient must make treatment decisions. Since that decision frequently needs to be made when the individual is no longer capable of speaking for himself/herself, living will legislation permits and encourages patients and prospective patients to express their desires while still competent to do so. See Freamon, *Death with Dignity Laws: A Plea for Uniform Legislation*, 5 SETON HALL LEG. J. 105, 119-137 (1982).

Right to Die

incompetent terminally ill patient, including judicial findings of incompetency and the law of guardianship, are explored. The crucial issue of the court's role in defining procedures required to terminate the treatment of an incompetent patient will then be examined.

The article concludes that legislation defining the rights and duties of physicians and patients is essential,¹³ not only because judicial decision-making has been erratic, confusing and inadequate, but because the right to refuse life-prolonging treatment in an advanced technological age is of significant dimension and requires the affirmative and comprehensive protection that only the legislative process can provide. The article concludes with a discussion of trends in the legislative area.

I. *Informed Consent*

The doctrine of informed consent is the common law foundation for the exercise of a patient's right to refuse life-prolonging medical treatment. Like the constitutionally based right to privacy, the right to refuse medical treatment rests on the belief that every individual has a right to determine what shall be done with his or her own body. In the context of the doctor-patient relationship, this has come to mean that the patient is entitled to be informed of all material facts pertaining to his or her condition and of any reasonably likely risks involved in proposed procedures.¹⁴ Similarly, the patient is entitled to be consulted before any new procedure is undertaken.¹⁵

The roots of the informed consent doctrine are ancient, dating back over eight centuries. As one court declared: "Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment."¹⁶

Yet until the very recent advent of a trend toward increasing judicial and societal acceptance of the concept of a "good death," many courts have inhibited the realization of patient self-determination in large part by exhibiting an extreme deference toward the medical profession's purported need for unfettered discretion in the treatment of patients.¹⁷ This approach was demonstrated by the New Jersey Supreme Court in

13. See notes 146-172 and text, *infra*.

14. W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 18, at 105-106 (4th ed. 1971).

15. *Id.* at 104.

16. See *Natanson v. Kline*, 186 Kan. 393, 406-407, 350 P.2d 1093, 1104 (1960).

17. See, e.g., *In re President of Georgetown Col., Inc.* 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964); *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S. 2d 666 (Sup. Ct. 1964).

discussing the right of a patient who had been the victim of an auto accident and had refused to consent to a blood transfusion:

When the hospital and staff are thus involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards. The solution sides with life, the conservation of which is, we think, a matter of State interest.¹⁸

This approach—resolving the purported conflicting interests of physician and patient on the side of the physician—has been thoroughly rejected by courts that have addressed the issue in other contexts over the past several years.¹⁹ But because of a parallel trend toward increasing judicial recognition of the applicability of the constitutionally based privacy doctrine to treatment decisions by dying patients, the new viability of the common law informed consent doctrine has not received adequate attention in the recent court decisions involving the withdrawal of life-prolonging treatment. Many of the leading decisions neglect to discuss the common law doctrine at all, relying exclusively on a privacy analysis. Those that do discuss the common law doctrine have presented it as a corollary to the right of privacy. In one recent decision, for example, the court said that “these two rights function in a complementary manner, simultaneously affording the incurably ill the right to determine at what point aggressive therapy should cease.”²⁰

Nevertheless, there remain several significant distinctions between the common law and constitutional right.²¹ Under certain circumstances, a court may prefer to rest its decision authorizing the refusal or with-

18. *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 583, 279 A.2d 670, 673 (1971).

19. *See, e.g.*, *Canterbury v. Spence*, 464 F.2d 772, 783-784 (D.C. Cir. 1972) (patient's cause of action is not dependent upon the standard of the profession for informed consent); *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 104 Cal. Rptr. 505, 514, 502 P.2d 1, 10 (1972) (“Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected”). *See generally* Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632 (1974).

20. *See, e.g.*, *In re Eichner*, 102 Misc. 2d 184, 423, N.Y.S. 2d 580, *modified*, 52 N.Y. 2d 363, 420 N.E.2d 64, 438 N.Y.S. 2d 200 (1981). *See also* notes 132-134 and text, *infra*.

21. Any common law right may be abrogated by legislative action. By contrast constitutional rights, as defined and clarified by the Supreme Court, are impervious to any change, except as may be accomplished by constitutional amendment. By the same token, common law rights are usually clearly defined and based upon centuries of judicial experience. Judicial recognition and definition of rights like the right of privacy is a relatively recent phenomenon. The process of constitutional adjudication remains in a tentative and formative stage. With few exceptions (such as the 13th Amendment) constitutional guarantees protect the individual from action or inaction by the government. The common law affects disputes between private individuals as well. Courts have not, however, shown any hesitancy in overcoming the “state action” requirement in deciding cases involving the terminally ill on constitutional grounds. *See, e.g.*, cases cited in note 7.

Right to Die

drawal of treatment on common law informed consent grounds rather than on the right of privacy.²²

II. *The Right To Refuse Treatment*

Arising as a corollary of the law of informed consent and drawing on ancient guarantees of individual self-determination as its doctrinal basis, the common law right to refuse medical treatment is now firmly recognized. Although many of the more recent decisions rest their analysis on the privacy right²³ several courts have made it clear that a competent adult patient generally has an unqualified common law right to refuse life-prolonging medical treatment.

Erickson v. Dilgard,²⁴ a 1962 decision by a lower New York court, presaged the trend and is often cited as the first case recognizing the right in this context. The court in *Erickson* declined to accept the argument presented by the prosecutor that the patient's unexplained refusal to consent to a blood transfusion amounted to suicide under the penal law. The court reasoned that Dilgard's act was not suicide, since his condition had not been caused by his own hand. Citing "fundamental concerns inherent in our system of government," the court upheld the refusal as a legally protected right, stressing the fact that the patient was at all times competent to make the decision. This reasoning has not been seen again until recently, an indication of the farsightedness of the *Erickson* court.²⁵

22. See, e.g., *Eichner v. Dillon*, 73 A.D. 2d 431, 426 N.Y.S. 2d 517 (1980).

23. See, e.g., *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980), *aff'g*, 362 So. 2d 160 (Fla. 1978); *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E. 2d 1232; *In re Quackenbush*, 156 N.J. Super. 282 (N.J. Super. Ct. Ch. Div.), 383 A.2d 785 (1978); *In re Yetter*, 62 Pa. D. & C.2d 619 (Northampton Cty. 1973); *In re Petition of Nemser*, 51 Misc. 2d 616, 273 N.Y.S. 2d 624 (1966).

In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), and *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977), each involved incompetent patients. Both courts, in dicta, recognized the right of competent adults to refuse medical treatment.

24. 44 Mis. 2d 27, 252 N.Y.S. 2d 705 (Sup. Ct. 1962).

25. Many of the cases decided since *Erickson* have involved Jehovah's Witnesses, thereby raising, in addition to the common-law consent doctrine, the First Amendment right to free exercise of one's religious beliefs. Decisions involving refusals to consent to treatment for religious reasons vary widely from jurisdiction to jurisdiction and depend upon the particular facts. *In re Brooks Estate*, 32 Ill. 2d 381, 205 N.E. 2d 435 (1965), involved a female Jehovah's Witness who refused a transfusion necessary for treatment of a peptic ulcer. The Supreme Court of Illinois vacated a lower court transfusion order, *post facto*, on First Amendment free exercise grounds. The Court emphasized the patient's awareness of the consequences of the decision, the strength of her religious belief and the court's reluctance to impose value judgments concerning that belief. *In re Osborne*, 294 A.2d 373 (D.C. App. 1972), upheld an unmarried patient's right to refuse treatment on 1st Amendment religious grounds, even though two minor children would lose their sole parent as a result.

However, many recent decisions have held against the exercise of the right, reasoning that

The rationale advanced in *Erickson* in 1962 did not appear again in any reported court decision until 1979, when another judge of the same lower New York court announced his decision in *Eichner v. Dillon*.²⁶ Unlike the courts in the leading termination-of-treatment cases of the prior several years,²⁷ the trial court in *Eichner* declined to rule on the question of whether the right to privacy is applicable to a case involving the withdrawal of life-prolonging treatment, arguing: first, that the law with respect to its applicability is unsettled; and second, that since the right to privacy emanates from the Fourteenth Amendment, a showing of state action is required in order for the right to apply.

Having failed to find the privacy doctrine to be dispositive of the issue, the *Eichner* court turned to "existing and relevant common law rights." Pointing out that "[t]he common law has long reflected a concern for the individual's right of self-determination," the trial court concluded that the common law right of informed consent permits a competent adult to refuse life-prolonging medical treatment.²⁸ Although the patient was incompetent at the time of decision, he had previously expressed a firm view against "extraordinary" care.

Ruling on appeal, the Appellate Division cited as controlling the leading cases that have found the constitutional right to privacy to be applicable to withdrawal-of-treatment cases. The court observed: "The decision by the incurably ill to forego medical treatment and allow their inevitable course is so manifestly a 'fundamental' decision in their lives that it is virtually inconceivable that the right to privacy would *not* ap-

the preservation of life and the protection of incompetents are sufficiently important societal concerns to warrant compulsory treatment even in the face of an attempted good faith exercise of religious belief. See, e.g., *In re President of Georgetown College, Inc.*, 351 F.2d 1010 (D.C. Cir. 1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972); *Raleigh Fitkin-Paul Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (Sup. Ct. 1964), *cert. denied*, 377 U.S. 985 (1964); *In re Melideo*, 88 Misc. 2d 1974, 390 N.Y.S.2d 523 (Sup. Ct. 1976). Resolution of First Amendment questions involving the free exercise of one's religious beliefs triggers application of a balancing test: the state's interest in life and public order are weighed against the right of the individual to freely exercise his/her religion. This is an analytical framework that permits courts to speculate on and express their own views of societal concerns.

26. 102 Mis. 2d 184, 423 N.Y.S. 2d 580 (Sup. Ct. 1979). Brother Joseph Fox was a member of the Society of Mary, a Catholic religious order. While undergoing a routine hernia operation, he suffered cardiac arrest, with resulting loss of oxygen to the brain and substantial brain damage. Fox lapsed into a vegetative state, with no reasonable chance of recovery. Father Phillip Eichner requested that the hospital remove the respirator which was keeping Brother Fox alive. When the hospital refused, Eichner instituted proceedings seeking his appointment as committee of the person and property of Brother Fox, with authority to direct removal of the respirator. All of Brother Fox's surviving relatives supported the request. Brother Fox's had made his views known on extraordinary care prior to the operation.

27. See note 7, *supra*.

28. *In re Eichner*, 102 Mis. 2d 184, 200, 203, 423 N.Y.S. 2d 580, 591, 593 (1979).

Right to Die

ply to it".²⁹

Surprisingly, the New York Court of Appeals rejected the Appellate Division's privacy analysis and, with that modification, affirmed on the bases of the trial court's reasoning, quoting Judge Cardozo's common law adage announced sixty-five years earlier in *Schloendorff*: "[every person] of adult years and sound mind has a right to determine what should be done with his own body" ³⁰ Finding that Brother Fox, the patient, had indeed made a clear prior expression of his wishes, the court held that his doctors were bound by the common law to follow the instructions of his guardian. There was, consequently, no reason to reach the constitutional issues involved.³¹

The *Eichner* decision, beyond doubt, establishes the viability and strength of the common law right of competent patients to refuse treatment. Indeed, where a prior expression of wishes is clearly articulated, *Eichner* will certainly dictate the result in New York.

In a companion case, *In re Storar*,³² the Court of Appeals reached a contrary result. Although the facts of the *Storar* matter were quite different from those in *Eichner*,³³ one might have expected the court to reach a

29. *Eichner v. Dillon*, 73 A.D. 2d 431, 459, 426 N.Y.S. 2d 517, 537 (App. Div. 1980) (emphasis in original).

30. *Eichner* (decided with *In re Storar*), 52 N.Y.2d 363, 369, 420 N.E.2d 64, 438 N.Y.S.2d 266, 272 (1981).

31. *Id.*

32. *Id.*

33. John Storar, age fifty-two, was a lifelong resident of the Newark (New York) Development Center, an institution operated by the New York State Office of Mental Retardation and Developmental Disabilities. Storar had always been profoundly mentally retarded. His IQ was assessed at between 10 and 20, with a corresponding mental age of between one and two years. At the time of trial, in November of 1980, he was only able to express himself by grunts and growls and was completely unable to adhere to daily routines, thereby requiring round-the-clock supervision.

In July, 1979, Storar's physicians determined that he was suffering from invasive, transitional carcinoma of the bladder. On March 17, 1980, his condition was diagnosed as terminal and incurable. Between March and November, the patient's condition substantially deteriorated. The cancer metastasized to Storar's lungs, and testimony indicated probable metastasis of his liver and brain as well. Lesions of the bladder caused extensive bleeding.

On May 13, 1980, Storar's attending physicians ordered blood transfusions to counteract his massive blood loss. After the blood transfusions commenced, Storar's condition continued to worsen, and by November could only be described in the most tragic terms:

Although he is still ambulatory and can feed himself, Storar's physical condition has steadily deteriorated. In March, 1979, he weighed 150 pounds. He is pale, has diminished appetite and is subject to frequent attacks of nausea and emesis (vomiting). He naps frequently and spends most of his time in his room, either in bed or on the commode. In contrast to his behavior prior to the commencement of the transfusions, Storar now very seldom ventures outside his room Even after blood transfusions he remains weak.

In addition, and as a direct result of the transfusions, there is frequent clotting in Storar's urine which makes urination quite painful. The clots increase in both size and number and he bleeds extensively after a transfusion. Each time he goes to the bathroom, the blood and clotting are present. He becomes very upset when he urinates

similar result, since both patients were incurably ill. The Court's refusal to authorize termination of treatment in *Storar* raises grave questions about the efficacy of the common law right when it is asserted on behalf of a patient who has never been competent.

Traditionally, physicians when dealing with questions of proposed treatment of minors and mental incompetents have been required to obtain the informed consent of parents, guardians, next-of-kin, or any other persons who stand *in loco parentis*.³⁴ An emergency, or other life-threatening event, may excuse the doctor's failure to obtain the consent of next-of-kin, on the theory that consent is presumed where a life is in danger.³⁵

If, however, the parent or guardian has made a prior objection to proposed treatment, the physician is well advised to seek judicial approval of any treatment to be administered, whether life-saving or not. The question before the court will be whether it is in the incompetent's best interest to forego treatment. While it is generally true that parents have no right to deprive their children of life-saving treatment,³⁶ the *Storar* factual pattern is fundamentally distinguishable from the typical child neglect case involving an irrational parental refusal of medical care. The *Storar* court held that the New York common law prohibited withdrawal in circumstances where the patient had never been competent, even though his mother refused to consent to further treatment on the basis that continued blood transfusions would not be in his best interest. Although cases interpreting child neglect statutes have held in favor of compulsory treatment, the issue has always turned on an analysis of the incompetent's best interests. Since non-treatment may in many instances be in the patient's best interest, the *Storar* court's result

blood, particularly because it seems he has made a primitive connection between the blood going in and the blood coming out.

There is no question that Storar's illness causes him intense pain and discomfort One physician described it as a "strangling pain," characterized by frequent involuntary contractions of the bladder in an attempt to expel the cancerous mass. The pain and the need for medication increase as the cancer spreads. 106 Misc. 2d at 882-83, 433 N.Y.S. 2d at 392.

The trial court's decision authorizing termination of blood transfusions was affirmed by the New York intermediate appellate court, but the orders of both these courts were stayed and the transfusions continued during the entire appeals process. The Court of Appeals reversed both lower courts.

34. For obtaining parental consent for proposed treatment of a minor *see, e.g.*, *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) and *Perry v. Hodgson*, 168 Ga. 678, 148 S.E. 659 (1929). For obtaining consent from guardians for proposed treatment of an incompetent, *see, e.g.*, *In re Spring*, 1979 Mass. App. Adv. Sh. 2469, 399 N.E.2d 493, *rev'd*, 405 N.E. 2d 115 (Mass. App. 1980).

35. *See, e.g.*, *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912); *Tabor v. Scobee*, 254 S.W. 2d 474 (Ky. Ct. of App. 1957).

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

Right to Die

becomes untenable in that it presumes that non-treatment will always be injurious.³⁷

A. *Right to Privacy: The Constitutional Doctrine*

Although the United States Supreme Court has not yet considered the question of whether the constitutionally recognized right to privacy is applicable to the terminally ill, a substantial number of courts, relying on a recent series of Supreme Court cases in the privacy area³⁸ have held that under some circumstances there is a constitutional right to die.

Recent Supreme Court decisions³⁹ that have rested upon privacy grounds have been notably imprecise, offering little to indicate the parameters of the doctrine for future cases. Since lower courts ordinarily hesitate to extend an evolving constitutional doctrine into an area not yet specifically reached by a decision of the U.S. Supreme Court, it is noteworthy that every recent refusal-of-treatment decision except one,⁴⁰

37. Cf. *Matter of Hofbrauer*, 47 N.Y. 2d 648, 419 N.Y.S. 2d 936, 393 N.E. 2d 1009 (1979) (allowed alternative treatments favored by parents, rather than conventional chemotherapy for boy with cancer) and *In re Storar*, 52 N.Y. 2d 363, 389, 420 N.E. 2d 64, 77-78, 438 N.Y.S. 2d 266, 280 (1981) (Jones, J., dissenting).

38. *Griswold v. Connecticut*, 381 U.S. 479 (1965), is frequently cited as the first modern Supreme Court decision to identify a constitutionally based right to privacy. Prior Supreme Court rulings, as early as its 1891 decisions in *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891), had protected various privacy interests, but had tended to base the right on other more specific constitutional protections.

In the opinion of the Court and in three separate concurring opinions, the six justices constituting the majority in *Griswold* cited a variety of constitutional provisions as providing sources of the privacy right. Writing for the Court, Justice Douglas declared that five amendments—the 1st, 3rd, 4th, 5th and 9th—contain certain specific guarantees that “have penumbras, formed by emanations from those guarantees that help give them life and substance.” Various guarantees create zones of privacy, *Griswold v. Connecticut*, 361 U.S. at 484. A concurring opinion by Justice Goldberg that was joined by Chief Justice Warren and Justice Brennan relied primarily upon the ninth amendment, finding that it was intended to insure that additional fundamental rights not among those specifically enumerated in the first eight amendments, were reserved to the people. Justices Harlan and White, each writing separately, grounded their concurrence in the Court’s judgment upon rights they declared to emanate from the liberty concept contained in the due process clause of the 14th amendment.

Although judicial disagreement over the exact source of the privacy right continues, the doctrine has nevertheless been firmly established and its parameters have been significantly expanded by a series of post-*Griswold* Supreme Court cases in which the privacy doctrine has been held to encompass decisions involving contraception, *Eisenstadt v. Baird*, 405 U.S. 438 (1972), family relationships, *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632 (1974), possession of pornography in the privacy of the home, *Stanley v. Georgia*, 394 U.S. 557 (1969), and the termination of pregnancy, *Roe v. Wade*, 410 U.S. 113 (1973). Yet an examination of the constitutional analysis provided in these opinions reveals that the modern privacy doctrine is an abstract and fluid concept impossible to pinpoint with any degree of precision. It has been said that “[f]ew concepts . . . are more vague or less amenable to definition and structured treatment than privacy,” Dixon, *The Griswold Penumbra: Constitutional Charter for an Expanded Law of Privacy?* 65 MICH. L. REV. 64, 199 (1977).

39. See, e.g., *Whalen v. Roe*, 429 U.S. 589 (1977); *Paul v. Davis*, 424 U.S. 693 (1976); *Zablocki v. Redhail*, 434 U.S. 374 (1978).

40. This exception is *In re Storar*, 52 N.Y. 2d 363, 420 N.E.2d 64, 438 N.Y.S. 2d 266

has rested primarily or exclusively upon constitutional privacy grounds, and several have done so with a minimum of legal analysis.

When faced with the question of whether the right to privacy extends to terminally ill patients who decline life-prolonging procedures, most state courts have exhibited little hesitation in finding that the right does extend to persons in such circumstances. An examination of the underpinnings of the privacy doctrine confirms that privacy interests are clearly present in treatment decisions by the terminally ill, and that decisions recognizing this principle are on firm footing.

Like the related informed consent doctrine, the roots of the constitutional right of privacy are found in the old common law right of self-determination. It was first found to be of constitutional dimension by Justice Brandeis in his dissenting opinion in *Olmstead v. United States*,⁴¹ in which he said: "The protection guaranteed by the Amendments...conferred, as against the government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men."⁴²

There appear to be two branches of the privacy doctrine in its modern form. The first focuses upon the right of individuals to make decisions about important private and personal matters without fear of undue or excessive governmental interference. The right has been variously described as the "freedom of choice with respect to certain basic matters of procreation, marriage and family life,"⁴³ "freedom of action in a sphere contended to be 'private,'"⁴⁴ an "interest in independence in making certain kinds of important decisions,"⁴⁵ and the right "to shape [one's] own life as [one] thinks best, do what [one] pleases, go where [one] pleases."⁴⁶ The common thread in these cases is that persons are entitled to be free from governmental interference with, or regulation of, certain kinds of private and personal behavior in the absence of a showing of countervailing governmental interests of substantial magnitude.

The second branch of the constitutional right of privacy rests upon the concept of a right of physical autonomy. In essence, it is the common law informed consent doctrine elevated to constitutional stature—a modern recognition that treatment or other physical intrusion against one's will, historically has been viewed as an invasion of bodily integrity

(1981), which rested, in part, upon the common-law informed consent doctrine. See discussion of *Storar* at pages 87-89, *infra*.

41. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

42. *Id.* at 478.

43. *Kelley v. Johnson*, 425 U.S. 238, 244 (1976).

44. *Paul v. Davis*, 424 U.S. 693, 713 (1976).

45. *Whalen v. Roe*, 429 U.S. 589, 600 (1977).

46. *Kent v. Dulles*, 357 U.S. 116, 126 (1958).

Right to Die

requiring the existence of a countervailing interest sufficient to justify the intrusion. A leading constitutional scholar has said of this branch of the privacy doctrine: "[I]t is undeniable that the body constitutes the major locus of separation between the individual and the world and is in that sense the first object of each person's freedom. . . ."⁴⁷ Although they have not always framed this right in privacy terms, a number of courts over the years have held that government-imposed bodily intrusions are permissible only upon a showing of substantial necessity.⁴⁸

What is essentially unique to cases involving treatment of the terminally ill is that the two separate but interrelated elements of the "right to be let alone"—bodily integrity and the freedom to make decisions about certain fundamental personal matters—fuse in the context of a decision by the patient not to receive life-prolonging treatment. The privacy interest asserted in such cases is significant not only because the decision to accept death is fundamental, sacred, and private but also because compelled treatment involves direct invasion of the patient's bodily integrity.⁴⁹

1. *Limitations on Privacy*

Few constitutional rights are absolute. Even such cherished and long recognized rights as the freedoms of speech⁵⁰ and religious practice⁵¹

47. L. TRIBE, *AMERICAN CONSTITUTIONAL LAW*, at 913.

48. *E.g.*, *Rochin v. California*, 342 U.S. 165 (1952), *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250 (1891), see also TRIBE, *AMERICAN CONSTITUTIONAL LAW*, 314-15, 917, noting that a government action which invades an individual's bodily privacy requires strong justification. Generally, the more intrusive the bodily invasion, the greater the burden placed upon the government to justify the invasion. It has been suggested by Tribe that the appropriate factors for determining the permissible extent of bodily invasion are presence and degree of physical pain, risk of irreversible injury, possible disfigurement or other complication.

49. One could legitimately argue that proscriptions against abortion also constitute a direct bodily invasion since they force a woman to carry an unwanted pregnancy to term. The degree of invasion in such cases is great; nevertheless, the bodily invasion is certainly more direct, and therefore more objectionable, in cases involving treatment against the patient's will.

50. The protection of speech from government sanction can be limited where the speech in question poses a "clear and present danger" of violent illegal conduct. *See, e.g.*, *Schenck v. United States*, 249 U.S. 47 (1919). Also, some types of speech which are considered to be offensive or of no social value have been denied full constitutional protection in certain circumstances. *See, e.g.*, limitation on commercial speech, *Capital Broadcasting Co. v. Mitchell*, 333 F. Supp. 582 (D.D.C. 1971), *aff'd, sub nom. Capital Broadcasting Co. v. Acting Attorney General*, 405 U.S. 1000 (1972); limitation on "fighting words," *Chaplinsky v. New Hampshire*, 315 U.S. 568 (1942); limitation on obscenity, *F.C.C. v. Pacifica Foundation*, 438 U.S. 726 (1978).

51. Freedom of religion has been limited where religious practices were dangerous or illegal. *See, e.g.*, *United States v. Reynolds*, 98 U.S. 145 (1878) (polygamy conviction affirmed over defendant's religious freedom objection); *United States v. Kuch*, 288 F. Supp. 439 (D.D.C. 1968) (assertion that sale and use of illegal drugs was protected as part of defendant's

and the right to equal protection of the law have been limited.⁵² Generally, if a governmental objective of sufficient magnitude is furthered or seems reasonably likely to be furthered by a governmental regulation that infringes upon constitutional rights, the regulation is presumptively valid and will be upheld,⁵³ except where a classification is "suspect"⁵⁴ or a regulation interferes with a "fundamental right."⁵⁵ In those cases, the challenged regulation is presumptively invalid, and will be upheld only where it is found that the regulation serves a compelling state interest that cannot otherwise be achieved by less restrictive means.

The notion of the "fundamental right" is a vague concept in constitutional law. Initially it referred only to those rights enumerated in the Bill of Rights that were deemed by the court to be sufficiently important or "fundamental" to be incorporated into the 14th amendment's proscription against arbitrary state action.⁵⁶ The "incorporation" of these fundamental rights into the Fourteenth Amendment occurred in a piecemeal fashion. In recent years the concept of fundamental rights has been expanded on an *ad hoc* basis to include more broadly defined rights like privacy and travel.⁵⁷ As a consequence, it is quite difficult to define the precise boundaries of the term. In some circumstances, the

religion denied); *State ex. rel. Swann v. Pack*, 527 S.W.2d 99 (Tenn. 1975), *cert. denied*, 424 U.S. 954 (1976) (use of poisonous snakes in religious services not permitted).

52. The Constitutional right to equal protection of the law does not guarantee absolute equality or equal advantage since a challenged action may not be violative of equal protection if it rationally furthers a legitimate state purpose. Some state action resulting in disadvantage to individuals has been upheld over challenges on equal protection grounds. *See, e.g.*, *Vorchheimer v. School Dist.*, 532 F.2d 880 (2d Cir. 1976), *aff'd without opinion*, 430 U.S. 703 (1977) (no equal protection violation where sex-segregated public high schools offered essentially equal educational opportunities); *San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. (1973) (no equal protection violation where school financing system was based on local property tax); *Dandridge v. Williams*, 397 U.S. 471 (1979) (no equal protection violation where state placed absolute limit on monthly welfare grant regardless of family size).

53. *See, e.g.*, *Kahn v. Shevin*, 416 U.S. 351 (1974) (upholding a discriminatory Florida tax law based on a reasonable distinction and legitimate state policy). Justice Douglas noted that the courts will not "substitute their social and economic beliefs for the judgments of legislative bodies which are elected to pass the laws." *Id.* at 356 n. 10 (citing *Ferguson v. Skrupa*, 372 U.S. 726, 730 (1962)).

54. The Supreme Court has deemed classification by race, *e.g.*, *Loving v. Virginia*, 388 U.S. (1967), or alienage, *e.g.*, *Graham v. Richardson*, 403 U.S. 365 (1971), to be "suspect" classifications. The Court has also treated classifications based on gender, *Frontiero v. Richardson*, 411 U.S. 677 (1973), and illegitimacy, *e.g.*, *Levy v. Louisiana*, 391 U.S. 68 (1967) as "suspect" in some cases.

55. "Fundamental rights" include such rights as: the right to travel, *Shapiro v. Thompson*, 394 U.S. 618 (1969); the right to vote, *Dunn v. Blumstein*, 405 U.S. 330 (1972); and the right of access to meaningful litigation, *Boddie v. Connecticut*, 401 U.S. 371 (1971).

56. *See* L. TRIBE, *AMERICAN CONSTITUTIONAL LAW*, 567-68 (1978) for a discussion of selective incorporation and a list of rights which have been incorporated into the Fourteenth Amendment and are therefore protected from state action without due process.

57. The right to privacy was considered a fundamental right in *Roe v. Wade*, 410 U.S. 113 (1973); the right to travel was so considered in *Shapiro v. Thompson*, 394 U.S. 618 (1969).

Right to Die

relationship between the individual right and the governmental interest is not static. Because the one is balanced against the other, a growth or decline in one has an impact on the other.⁵⁸ This shifting between competing individual rights and governmental interests is present in many cases involving termination of life-prolonging treatment. *In re Quinlan*,⁵⁹ decided by the New Jersey Supreme Court in 1976, provided the first articulation of the basic formula for application of the balancing test in the context of the right of terminally ill patients to refuse medical treatment on constitutional privacy grounds:

We think that the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest.⁶⁰

Thus, under the *Quinlan* formulation, the invasiveness of the unwanted treatment and the condition of the patient are the crucial factors in determining whether the right is sufficiently fundamental to overcome countervailing state interests. Utilizing this formulation, the *Quinlan* Court distinguished *Heston* and other cases in which treatment had been authorized despite the patient's refusal to consent, on the grounds that in those cases "the medical procedure required (usually a transfusion) constituted a *minimal bodily invasion* and the *chances of recovery and return to functioning life were very good*."⁶¹ In contrast, Karen Ann Quinlan was irreversibly comatose and the degree of bodily invasion sought to be discontinued was substantial.⁶²

The balancing test articulated by the *Quinlan* court might be construed to imply that both these factors—impending death and significant bodily invasion—must be present in order for a patient's right to refuse to be upheld. However, several subsequent decisions⁶³ have de-

58. This shifting of interests is most clearly observable in the landmark *Roe v. Wade* case, 410 U.S. 113 (1973), which involved a Texas abortion statute. Holding that "the rights of personal privacy includes the abortion decision", at 154, the Court held that until the point of fetal viability is reached, a pregnant woman's fundamental right to privacy outweighs the state's important but not yet compelling interest in protecting human life. At the point of viability, however, the balance shifts. Because "the fetus then presumably has the capability of meaningful life outside the womb", at 163, the state interest in protection of the fetus becomes sufficiently compelling to outweigh the woman's right to privacy. In the third trimester, then, the state may proscribe abortion despite the incursion into the pregnant woman's privacy interest, except when her life would be placed in jeopardy if she were forced to carry the pregnancy to term.

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

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

61. *Id.* at 41, 355 A.2d at 664 (emphasis added).

62. Karen Quinlan's father sought discontinuance of the respiratory support systems.

63. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417, 426 (1977); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E. 2d 134, 138 (1978).

emphasized the element of bodily invasion in their formulations of the balancing test, focusing primarily or exclusively on the hopelessness of the patient's condition. These decisions particularly looked to whether the continuation of life would be artificial and temporary and whether the treatment would be life-prolonging rather than life-saving.

Significantly, two decisions, *In re Quackenbush*⁶⁴ and *Lane v. Candura*,⁶⁵ have held that, where bodily invasion is extensive, the privacy right overcomes state interests even in the absence of a poor prognosis for recovery. In both of these cases, however, the bodily invasion was extreme-amputation of one or more limbs. The *Quackenbush* court, which had also written the trial court opinion in *Quinlan*, explained:

[T]here is a suggestion [in *Quinlan*] of a need for a combination of significant bodily invasion *and* a dim prognosis before the individual's right of privacy overcomes the State's interest in preservation of life. Under the circumstances of this case, I hold that the extensive bodily invasion involved here—the amputation of both legs above the knee and possibly the amputation of both legs entirely—is sufficient to make the State's interest in the preservation of life give way to Robert Quackenbush's right of privacy to decide his own future *regardless of the absence of a dim prognosis*.⁶⁶

Thus, the *Quinlan* holding has been expanded substantially, and a patient's right to refuse treatment has been upheld where the patient was not comatose,⁶⁷ where there was minimal bodily invasion but the patient was terminally ill,⁶⁸ and where the patient's prognosis with treatment was good but involved a substantial degree of bodily invasion.⁶⁹

2. *The State's Interests*

Decisions applying a privacy analysis to situations involving the termination of treatment have identified a total of four countervailing state interests.⁷⁰

64. *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (N.J. Super. Ct. Ch. Div. 1978).

65. *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E. 1232 (1978). In *Lane*, the patient knew that death would result from her refusal to allow the amputation of her gangrenous right leg. The Appeals Court reversed the Probate Court's judgment authorizing the patient's daughter to be the guardian for the purpose of consenting to the amputation. The Court's reversal was based on the premise that the irrationality of the patient in refusing amputation does not constitute legal incompetence to make that decision.

66. *In re Quackenbush*, 156 N.J. Super. 282, 290 (N.J. Super. Ct. Ch. Div. 1978), 383 A.2d 785, 789 (1978) (emphasis added) (the court defined "dim prognosis" as an inability to return to a cognizant, sapient life).

67. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417; *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So.2d 359; *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785.

68. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417; *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E. 2d 134.

69. See, e.g., *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785; *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E. 2d 1232.

70. Courts consider the state's interests in: 1) preservation of human life, 2) protection of

Right to Die

a. *The Preservation of Life*

Associate Justice Paul Liakos, writing for the Massachusetts Supreme Judicial Court in *Superintendent of Belchertown State School v. Saikewicz*,⁷¹ cited the preservation of life as the most significant of the four state interests asserted in that case.

Courts, upholding the right of terminally ill patients to refuse treatment, have differentiated between the state's interest in saving life on the one hand and prolonging dying on the other. Reliance is placed upon the fact that, in the latter case, "the patient's situation [is] wretched and the continuation of his life temporary and totally artificial."⁷² One such opinion posed the issue this way:

What benefits accrue to the patient by an unauthorized invasion of the patient's body for purposes of medical treatments which merely delay death? . . . What are the State's interests in prolonging a vegetative life, where death is certain? The administration of treatment by a physician in this situation is somewhat analogous to the non-medical situation of placing a life preserver, which will slowly lose its quality of buoyancy, on a comatose patient, who cannot regain consciousness, who is drowning in water and cannot be rescued. What interest of the State is served by engaging in such acts?⁷³

In those cases in which the patient was near death and the treatment offered was merely a brief extension of life, it has been declared that the State's interest in preserving life does not extend to the prolongation of dying.⁷⁴ But in two cases upholding a competent patient's right to refuse treatment which would have been life-saving rather than merely life-prolonging, the courts did not even mention the existence of a State interest in preserving life⁷⁵. These cases posit the rationale that the presence of such an interest should not be an obstacle for a competent person who chooses not to live. Such reasoning would allow for judicial condonation of active euthanasia and suicide. However, the present case law stresses that the privacy right, although fundamental, is not absolute. The dimmer the prognosis, the less likely it will be that the

third parties, 3) protection against suicide and 4) maintenance of the ethical integrity of the medical profession. *See, e.g.*, *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 741, 370 N.E. 2d at 425.

71. *Id.*

72. *Satz v. Perlmutter*, 362 So. 2d at 162.

73. *Dockery v. Dockery*, No. 51439 at 13 (Tenn. Ch. App.), *aff'd*, 559 S.W. 2d 952 (1977).

74. *See, e.g.*, *Satz v. Perlmutter*, 362 So. 2d at 162; *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 741-742, 370 N.E. 2d at 425; *In re Storar*, 106 Misc. 2d 880, 886, 433 N.Y.S. 2d 388, 393, *aff'd* 78 A.D. 2d 1013, 434 N.Y.S. 2d 46 (1980), *rev'd*, 52 N.Y. 2d 363, 438 N.Y.S. 2d 266 (1981).

75. *In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S. 2d 523 (N.Y. Sup. Ct. 1976); *In re Yetter*, 62 Pa. D. & C. 2d 619 (Northampton Cty. 1973).

court will find the State's interest in preserving life compelling, since the nature and quality of that life is said to be diminished.

b. *The Protection of Third Parties*⁷⁶

In several pre-*Quinlan* cases, in which the patient unsuccessfully asserted a right to refuse treatment based upon the informed consent doctrine, the courts cited as one justification for compelling treatment the state's interest in preserving the life of a parent with a dependent child, thereby protecting the interests of the child in the survival of its parent.⁷⁷ Since none of the post-*Quinlan* cases utilizing the privacy analysis have involved a patient with dependents, it is unclear whether the patient's privacy right would be outweighed by the State's interest in protecting a dependent third party. Certainly in those cases involving a terminally ill patient, it is unlikely that a court would find that the interests of a child would be furthered by the forced prolongation of the patient's death. It seems clear that an "easy death" for a parent would benefit the child emotionally as well as financially. On the other hand, where life-saving (as opposed to death-delaying) treatment is refused, it is not inconceivable that a court might find that the protection of the child's interests in a living parent outweighs the parent's right to die.

c. *Protection of the Integrity of the Medical Profession*

Quinlan described this state interest as a "defense of the right of the physician to administer medical treatment according to his [or her] best judgment"⁷⁸ in circumstances where the patient has not consented to treatment but the physician's judgment is that such treatment is in the best interests of the patient.⁷⁹ The *Saikewicz* opinion cited a similar interest, but pointed to an increasing tendency in the profession to recognize that prolongation of life is not always good medicine from the point

76. See *Roe v. Wade*, 410 U.S. 113, 162-164 (1973), for a discussion of this State interest in a related context.

77. *E.g.*, *In re President of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir. 1964); *But see, In re Osborne*, 294 A.2d 372 (D.C. 1972). A very recent case involving the protection of a child's interest in a far more direct way is *Jefferson v. Griffin Spalding County Hospital Auth.*, 247 Ga. 86, 274 S.E. 2d 457 (1981). There, the mother refused to consent for religious reasons to a cesarean section that would necessarily involve blood transfusions, even though attending physicians advised her that the viable fetus was 99% certain to die if delivered vaginally. Since the mother's chance of surviving such delivery was 50%, the court rested its decision to compel treatment on two independent bases: preservation of the lives of child and mother. The mother was not terminally ill and presumably she would be restored to full health following treatment by routine procedure.

78. *In re Quinlan*, 70 N.J. at 40, 355 A.2d at 663 (1976).

79. *Cf. John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 582-583, 279 A.2d 670, 673 (1971).

Right to Die

of view of the patient's needs.⁸⁰ A recent survey of physician attitudes supports this analysis.⁸¹ Ironically, the physician's presence in court in a stance adversarial to the patient often results not from a personal view of what constitutes good medical practice but from overriding fears of criminal or civil liability.⁸²

Putting these considerations aside, however, there is little doubt that since the right to privacy is constitutionally based, it is superior to any governmental interest in protecting the integrity of the medical profession, and no case has held otherwise. This is certainly the implication of *Quinlan*. Indeed, a recent Supreme Court decision has suggested that "a doctor's right to administer medical care has [no] greater strength than his patient's right to receive such care."⁸³

d. *The Prevention of Suicide and Homicide*

Although most courts categorize these two interests as independent,⁸⁴ it is the State's asserted interest in the preservation of life that provides the primary justification for existing laws against both suicide and homicide. Those courts⁸⁵ that have discussed the state's interest in preventing suicide and homicide have factually distinguished the act of refusing life-saving treatment by a terminally ill patient on the ground that the death-producing agent in terminal cases is the illness itself.⁸⁶

B. *The Problem of Incompetency*

It is significant to note that in nearly every recent right to die case, the patient has been either unconscious, afflicted by mental retardation, or so debilitated by illness as to be incompetent.⁸⁷ This may be an indication that physicians usually respect and participate in the decisions of their competent terminally ill patients who decline treatment, thus obviating the need for court intervention; certainly it reflects the complexity

80. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 743-744, 370 N.E. 2d 417, 426-427 (1977).

81. *Death With Dignity: Technology v. Humanity*, THE PHYSICIAN SPEAKS, (July 1979) (published by ProData Communications).

82. See, e.g., *Satz v. Perlmutter*, 362 So. 2d at 161-162; *In re Dinnerstein*, 6 Mass. App. Ct. at 469-470, 380 N.E. 2d at 137; *In re Quinlan*, 70 N.J. at 48, 355 A.2d at 668.

83. See *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977).

84. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 743, n.11, 370 N.E. 2d at 426, n.11, where the court distinguishes the state interest in preventing suicide and distinguishes suicide from refusal of medical treatment.

85. See, e.g., *Satz v. Perlmutter*, 362 So. 2d at 162 (Fla. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E. 2d at 426, n.11, *Dockery v. Dockery*, No. 51439 at 14 (Tenn. Ch. App. 1977).

86. This is also factually distinguishable from active euthanasia. The state interest in preventing suicide is thus more difficult to overcome in active euthanasia cases.

87. The one exception is *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So. 2d 359 (Fla. 1980), which involved a fully competent, terminally ill, 73 year old man.

of the legal and moral issues a physician faces in the treatment—or non-treatment—of the terminally ill patient who is incompetent.

A dilemma is presented whenever a patient is suffering a lengthy and painful period of dying but is not competent to make decisions about whether or not he/she wants life sustaining treatment to commence or continue. The issue of who shall make that decision and the process by which it is made should involve several considerations: Who is most likely to make the decision that the patient, if competent, most likely would have made? What decision-making process would be within the financial reach of most patients? What process would be most capable of rendering a timely legal decision, since timeliness frequently is crucial? Cases such as *Quinlan*, *Spring*, *Perlmutter*, *Severns* and *Saikewicz*, although ultimately upholding the patient's right to decline treatment, have been criticized in part because of the lengthy delay, tremendous legal expense, and high emotional toll expended before an enforceable decision was reached.

1. *Guardianship*

Whenever an incompetent is unable to manage his/her own affairs, a court of appropriate jurisdiction is generally empowered to appoint a guardian with authority to make decisions about the incompetent's care and well-being.⁸⁸ The issues raised in this context are: (1) the appropriate legal standard to be applied in determining whether the alleged incompetent is sufficiently unable to manage his/her own affairs; (2) whether appointment of another with the power to make decisions on the incompetent's behalf is warranted; (3) the state of the law with respect to the court's selection of a guardian; (4) the guardian's adversarial responsibility and duty under circumstances in which his/her ward is a terminally ill patient where treatment decisions must be made.

a. *Judicial Findings of Incompetency*

It is a well-settled principle of the law of guardianship that all persons coming before the court are presumed to be competent. Where incompetency is alleged, the burden is upon the party alleging incompetency to prove it.⁸⁹ There is some variation from jurisdiction to jurisdiction as to the standard of proof required to establish incompetency. Some states require that incompetency be proved by clear and convincing evidence,⁹⁰ others require that it be proved merely by a preponderance of

88. See generally 39 Am. Jur. 2d, Guardian and Ward § 27.

89. *Grannum v. Berard*, 70 Wash. 2d 304, 422 P.2d 812 (1967); *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E. 2d 1232 (1978).

90. See *Grannum*, 70 Wash. 2d 304, 442 P.2d 812 (1967); *In re Myer's Estate*, 395 Pa. 459,

Right to Die

the evidence.⁹¹ In the case of the unconscious, infant, or mentally disabled patient, incompetency is an easily observable fact and a finding of incompetency will be uncontroverted. At other times, the determination remains problematic.

The legal definition of incompetency varies, depending upon the context in which it arises. The mental state that renders someone unable to stand trial, or to justify his commitment to a mental hospital, may be different from the mental state that renders someone unable to make treatment decisions on his own behalf.⁹² Since mental incompetency is a matter of degree, partial mental disorder or disease will not necessarily render a patient legally incompetent.⁹³

In a medical context, this means that the right to make one's own treatment decisions should include the right to make choices that may be considered irrational by the medical, judicial, and/or general community. One recent court opinion analogized the mental capacity to consent to medical treatment to that required to enter into a contract. The basic test is whether the patient has "sufficient mind to reasonably understand the condition, the nature and effect of the proposed treatment, attendant risks in pursuing the treatment, and not pursuing the treatment."⁹⁴

Not surprisingly, the application of this test has produced widely differing results. Four recent decisions, involving different factual questions of incompetency and sometimes employing different legal reasoning, provide an opportunity to explore the contours of the legal test for determining incompetency. Surgery was the treatment at issue in each of the cases; in three of the four—*Quackenbush*,⁹⁵ *Lane v. Candura*⁹⁶

150 A.2d 525 (1959); *In re Guardianship of Olson*, 236 Wis. 301, 295 N.W. 24 (1940); *In re Delany*, 226 S.W.2d 366 (Mo. Ct. App. 1950); *In re Estate of Head*, 94 N.M. 656, 615 P.2d 271 (Ct. App. 1980).

91. See *Lausche v. Commissioner of Public Welfare*, 302 Minn. 5, 225 N.W. 2d 366, cert. denied, 420 U.S. 993 (1974); *Sabon v. People*, 142 Colo. 323, 350 P.2d 576 (1960); *Keenan v. Scott*, 99 Okla. 63, 225 P. 906 (1924); *Missouri Pac. R. Co. v. Brazzil*, 72 Tex. 233, 10 S.W. 403 (1888); *Frates v. Treder*, 249 Cal. App. 2d 199, 57 Cal. Rptr. 383 (1967); *Zirt v. Pollock*, 25 A.D. 2d 920, 270 N.Y.S. 2d 85 (1966); *In re Conner*, 43 Del. Ch. 310, 226 A.2d 360 (App. Div. 1977).

92. See *In re Boyde*, 403 A.2d 744, 747 n.5 (D.C. Ct. App. 1979); *In re Petition of Memser*, 51 Misc. 2d 616, 273 N.Y.S. 2d 624 (Sup. Ct. 1966); *In re Schiller*, 148 N.J. Super. 168, 180, 372 A.2d 360 (App. Div. 1977).

93. See *In re Estate of Head*, 94 N.M. 656, 615 P.2d 271 (Ct. App. 1980). The court in *Head* observed: "Although the mental power may be reduced below the ordinary standard, yet, if there be sufficient intelligence to understand and appreciate the act, the mental ability . . . remains . . . It is enough if the mental faculties retained sufficient strength to comprehend the act to be done." 94 N.M. at 659-660, 615 P.2d at 274-275.

94. *In re Schiller*, 148 N.J. Super. 168, 180-81, 372 A.2d 360 (App. Div. 1977) and cases cited therein.

95. *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris Cty. Ct. Prob. Div. 1978).

96. *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978).

and *Northern*⁹⁷—amputation of a limb was necessary to prevent death. In the fourth, *In re Yetter*,⁹⁸ surgical biopsy was required to determine the possible presence of breast cancer.⁹⁹

Superficially, the cases reached opposite findings (in *Lane*, *Yetter* and *Quackenbush*, the patients were found to be competent while the patient in *Northern* was declared incompetent) not because different legal reasoning was applied, but because of significant differences in the mental states of the patients. In *Yetter*, *Lane* and *Quackenbush*, the courts found that the patient knew that an operation was necessary and that death would probably occur without it. In contrast, the *Northern* court found that the patient refused to consider the eventuality of death without treatment and refused to comprehend the facts of her condition—in other words, that she was delusional and that she consistently denied unpleasant reality.

It may well be that, in contrast to *Quackenbush*, *Yetter*, and *Lane*, Mary Northern really was incompetent in that she did not or could not understand the consequences of her refusal. The *Northern* court itself—mindful that there might be a critical reaction to its decision declaring the patient incompetent and ordering treatment in the face of her firm and repeated refusals to consent—insisted several times during the course of the opinion that it would respect her wishes if she were truly competent to express them. “If the patient would assume and exercise her rightful control over her own destiny by stating that she prefers death to the loss of her feet, her wish would be respected. . . . For the reasons just stated,

97. *State Dept. of Human Services v. Northern*, 563 S.W. 2d 197 (Tenn. Ct. App.), *cert. denied*, 575 S.W. 2d 946, *app. dismissed*, 436 U.S. 923 (1978).

98. *In re Yetter*, 62 Pa. D.&C. 2d 619 (Northampton City 1973).

99. Robert Quackenbush, a 72-year old patient at Morristown Memorial Hospital in New Jersey, refused to consent to the amputation of his legs, which had become gangrenous as a result of untreated arteriosclerosis. The hospital petitioned for the appointment of a guardian to consent to amputation. *See In re Quackenbush*, 156 N.J. Super. at 283-288, 383 A.2d at 786-788.

Mary Northern, the respondent in the *Northern* case was, like Quackenbush, also 72 years old, suffered from gangrenous feet, and refused to consent to amputation. Court proceedings in that case were instituted by the Tennessee Department of Human Services. *See State Dept. of Human Services v. Northern*, 563 S.W. 2d at 201-203.

Rosaria Candura, the alleged incompetent in *Lane v. Candura*, was a 77-year old widow suffering from gangrene of the right leg. Her daughter sought to be appointed guardian with authority to consent on her mother's behalf to amputation of the leg after Mrs. Candura refused the operation. *See Lane v. Candura*, 6 Mass. App. Ct. at 380-383, 376 N.E. 2d at 1233-1235.

In the *Yetter* case, the only one of the four that did not involve amputation, the respondent, Maida Yetter, was a patient at a Pennsylvania state mental hospital, having been diagnosed at the time of her commitment as a schizophrenic. A year after the commitment, a routine physical examination revealed the possible presence of breast cancer. The treating physician recommended a surgical biopsy and corrective surgery if indicated. Mrs. Yetter refused to consent to either the biopsy or the surgery; her brother instituted court proceedings. *See In re Yetter* at 620-621.

Right to Die

this is not a right-to-die case.”¹⁰⁰

In *Quackenbush*, the hospital-petitioner had presented a similar argument—that the patient’s decision to refuse the consent to amputation of his legs was such an aberration from normal behavior that it justified overriding his wishes for his own protection. The *Quackenbush* court rejected this reasoning on the grounds that it is circular and self-serving: the fact that the patient asserts a position contrary to that of the physician is cited as conclusive evidence of the patient’s incompetency to assert it. Although rejected in *Quackenbush*, this very reasoning was utilized by the *Northern* court to support its decision to compel treatment. *Northern* declared: “Capacity [to consent] means mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts.”¹⁰¹ But, like the argument rejected in *Quackenbush*, this reasoning also appears to be circular: a “rational” decision may become synonymous with those views perceived by the physician and/or court to be correct. As one legal commentator recently observed: “Everything has risks, and when someone is given the freedom of choice, it follows that he may choose badly.”¹⁰²

Courts facing difficult decisions involving incompetency should be wary of the danger of resting findings of incompetency on the mere fact that the patient’s expressed wishes conflict with the court’s or physician’s view of what is best for the patient, since this is an appropriate factor only *after* the patient has been determined, by a preponderance of the relevant evidence, to be incompetent.¹⁰³ A recent commentator proposes this useful test for making determinations concerning incompetency:

[T]he crucial elements of competence involve the person’s ability to give an informed refusal to consent, that is, they must appreciate the fact that they are ill, need care, and will die if they do not receive that care. Should a person meet this test, he or she will be considered competent to refuse to consent to medical treatment. The fact that the decisions run counter to the decision of the patient’s physician, family members, or differ from what a majority of people suffering from a similar ailment would decide, is not controlling.¹⁰⁴

100. *State Dept. of Human Services v. Northern*, 563 S.W.2d 197 (Tenn. Ct. App. 1978) (emphasis added), *cert. denied*, 575 S.W.2d 946 (1978), *appeal dismissed*, 436 U.S. 923 (1978).

101. *Id.* at 209.

102. *The Courier-Journal*, July 4, 1981, at B-6, col. 1, 2.

103. *See, e.g.*, *State Dept. of Human Services v. Northern*, 563 S.W.2d at 947 (although elderly woman objected to amputation of her feet, the entire case turned “upon whether or not [she was] competent to understand and make a reasonable decision to the proposed surgery.”).

104. Glantz, *Post-Saikewicz Judicial Actions Clarify the Rights of Patients and Families*, 6 MEDICOLEGAL NEWS, 9, 11 (1979).

b. *General Guardianship Principles*

Since consent to an invasion of the body is required even though a patient is not competent to make treatment decisions for himself, consent on behalf of the incompetent must be obtained from a guardian authorized by court order, statute, or custom before a particular medical procedure may be performed.¹⁰⁵ The common law *parens patriae*¹⁰⁶ doctrine authorizes courts, in the exercise of their equitable powers, to protect persons who are incapable of caring for themselves. *Parens patriae* has been defined as the responsibility of government ". . . to care for infants within its jurisdiction and to protect them from neglect, abuse and fraud."¹⁰⁷ Several courts have also cited as the source of their authority to appoint a guardian, or to directly authorize treatment, state statutes permitting them to take temporary custody of and authorize treatment for neglected or abandoned children.¹⁰⁸

The question of who should be selected by the court to act as guardian is related to larger considerations, including the appropriateness of court involvement, and the allocation of decision-making authority among the court, the patient's family, and physician. These issues are discussed at length below with a prefatory discussion of the law with respect to priorities in the appointment of a guardian, and the appropriate role to be played by a guardian appointed to represent the interests of an incompetent ward.

The paramount consideration in selection of a guardian is the welfare of the incompetent.¹⁰⁹ In a number of states, statutes contain provisions to guide the courts. The general rule, both by statute and common law, is that the next of kin or other family members (by blood or marriage) are presumed to be the first choice, on the theory that a close relative is most likely to know the wishes of the patient and to seek to protect his/her interests.¹¹⁰

Although there is a strong bias in almost every jurisdiction in favor of the next of kin or other relative, the court has wide discretion, and since

105. See, e.g., *Bonner v. Moran*, 126 F.2d 121, 122-123 (D.C. Cir. 1941).

106. "*Parens patriae*" literally means "parent of the country." BLACK'S LAW DICTIONARY 1003 (rev. 5th ed. 1979).

107. COWKLEY, *THE RIGHT TO LIVE* 239 (1969).

108. See, e.g., *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S. 2d 641 (Fam. Ct. 1970), *aff'd*, 377 App. Div. 2d 668, 323 N.Y.S. 2d 253 (1971), *aff'd*, 29 H.Y. 2d 900, 278 N.E. 2d 918, 328 N.Y.S. 2d 686 (1972) (court declared 15 year old boy a "neglected child" under a vaguely worded neglect statute and ordered surgery against parental wishes).

109. See generally Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645 (1977).

110. See, e.g., *Sullivan v. Dunne*, 198 Cal. 183, 244 P.343 (1926); *Kelley v. Kelley*, 129 Ga. App. 257, 199 S.E. 2d 399 (1973), *Re Guardianship of Ward*, 42 Hawaii 60 (1957); *Application of Danzig*, 23 Misc. 2d 591, 196 N.Y.S. 2d 211 (1960); *Kinser v. Hudgins*, 275 S.W. 2d 847 (Tex. Civ. App. 1955).

Right to Die

its first priority is the interests of the patient, it may prefer as its choice of guardian a stranger or more distant relative. In appointments to manage the business affairs of an incompetent, lack of knowledge or ability on the part of family members may lead the court to appoint a guardian from outside. Additional reasons are personality conflicts, intra-family dissension and absence of or minimal contact with the incompetent prior to the litigation. Perhaps the major justification for a court's selection of someone other than the next of kin is that the family member has material or personal interests in conflict with those of the incompetent patient.

c. *Guardians in Cases of Terminal Illness*

In a number of the leading cases involving the medical treatment of terminally ill incompetent patients, the courts have appointed a non-relative guardian *ad litem*,¹¹¹ usually an attorney.¹¹² Although they have not offered a rationale for their failure to follow the usual rule of preferring family members, there appear to be two possible explanations. The first is based upon the premise that if family members have sought discontinuation of treatment, and the patient is incompetent, then the family is viewed as having an interest adverse to the patient's, and appointment of a non-relative guardian is appropriate. A second rationale is that the role of the guardian *ad litem* involves legal representation of the incompetent, as contrasted with the traditional guardian's function of exercising general care and control over the incompetent's affairs. Where litigation is commenced by one or more members of the patient's family, most courts have considered it appropriate for the patient to have a legal representative.

This approach, consistent with the Anglo-American system of jurisprudence, is rooted in a belief in the efficacy of the adversarial process. Accordingly, it is thought that the factfinder is better equipped to resolve an issue when competing interests are adequately presented. Therefore, this procedural method has been applied to the resolution of treatment decisions for the terminally ill incompetent patient. In such circumstances, the role of the guardian can be quite different from the traditional role of "substitute parent," in which the best interests of the

111. A guardian *ad litem* is appointed specifically for purposes of representing the patient's interest in the lawsuit.

112. See, e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1975), *cert. denied*, 429 U.S. 922 (1976); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (Mass. 1977); *In re Spring*, 1979 Mass. Adv. Sh. 2469, 405 N.E. 2d 115 (Mass. 1980); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E. 2d 134 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris Cty. Ct. 1978); *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *In re Shiller*, 148 N.J. Super. 168, 372 A.2d 352 (Super. Ct. App. Div. 1977); *State Dept. of Human Services v. Northern*, 563 S.W. 2d 197 (Tenn. Ct. App. 1978); *In re Storar*, 52 N.Y. 2d 363, 420 N.E. 2d 64, 438 N.Y.S. 2d 266 (1981).

incompetent patient are determined and reported to the court after factual and, perhaps, legal investigation.

In recognition of the importance of the interest at stake, and in view of the prevailing judicial attitude toward the resolution of difficult legal and moral questions, most of the courts considering the issue of treatment of a terminally ill incompetent have defined the guardian's role as the advocate of the "pro-life position" in an adversarial context. In cases where the guardian may ultimately oppose treatment, courts may also appoint, at their discretion, a guardian *ad litem*, who must advocate the "pro-life" position.¹¹³ These competing interests are one aspect of the problem of who should decide upon the course of treatment.

2. *Who Should Decide*

Undoubtedly, the most perplexing and ethically difficult issue raised by the recent line of cases in this area concerns the allocation of decision-making power on behalf of the incompetent patient. Under such circumstances, how and by whom should vital treatment decisions be made? In the absence of legislation, it is the courts that must answer this sensitive and complex question. Inevitably, its resolution raises the problem of judicial self-restraint since courts often construct for themselves the role they will play in future decisions.

Three state supreme courts, those of New York, New Jersey and Massachusetts, have reached substantially different conclusions. *In re Quinlan* was decided by New Jersey's highest court in 1975; the decision in *Superintendent of Belchertown v. Saikewicz*¹¹⁴ was announced by the Massachusetts Supreme Judicial Court in 1977; *In re Storar*¹¹⁵ was handed down by the New York Court of Appeals in March of 1981.

a. *Judicial Decision-Making*

Saikewicz, the Massachusetts Supreme Court's first opinion in this area, created a storm of controversy when it announced its resolution of the question:

[S]uch questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on

113. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

114. *Saikewicz* was a profoundly retarded inmate of the Belchertown State School who contracted acute myeloblastic monocytic leukemia. Although the court addressed the constitutional issues raised by the parties and decided them in the patient's favor, the decision was interpreted as mandating litigation in every case involving incompetent patients. This interpretation caused a groundswell of litigation in the lower Massachusetts courts. See, e.g., *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *Lane v. Candura*, 6 Mass. App. Ct. 377 (1978). The matter was not resolved until *In re Spring*, 1979 Mass. Adv. Sh. 2469, 405 N.E. 2d 115 (Mass. 1980). See discussion in notes 122-127 and text, *infra*.

115. 52 N.Y. 2d 363, 420 N.E. 2d 64, 438 N.Y.S. 2d 266 (1981).

Right to Die

which the judicial branch of government was created.¹¹⁶

These words have been interpreted by medical and legal practitioners to mean that every instance of withdrawal of life-prolonging treatment from an incompetent patient necessitates prior judicial approval. The *Saikewicz* court appeared to be insisting that all future proceedings should be extensive and fully adversarial, regardless of the condition of the patient, the nature of the treatment at issue, or the view of the family. Critics of these portions of the *Saikewicz* opinion have cited evidence that, as a result of the decision, many hopeless, fatally ill patients were kept alive—unnecessarily and often cruelly—because physicians feared liability if they withheld treatment in the absence of judicial authorization.¹¹⁷ Doctors who previously had used their best medical judgment (with or without input from the incompetent's family) in the treatment of their terminally ill incompetent patients were advised by hospital attorneys that, in light of *Saikewicz*, the safest course was to continue treatment in the absence of judicial authorization to withdraw it, no matter how hopeless the condition or useless the treatment and no matter how much pain, suffering and indignity this caused the patient.¹¹⁸ Thus, the *Saikewicz* decision had the undesirable effect both of contributing to the needless suffering of patients and of interfering with the physician's own best medical judgment by creating the fear, whether realistic or not, of criminal and civil liability.

b. *Clarifying Saikewicz*

In re Dinnerstein,¹¹⁹ decided six months after *Saikewicz* by an appellate Massachusetts court, significantly modified the adverse impact of *Saikewicz*. The petition, filed by Dinnerstein's physician in the belief that he was required to do so under *Saikewicz*, sought the court's authorization to place a "no code" order¹²⁰ in the patient's chart. After a hear-

116. 373 Mass. at 759, 370 N.E. 2d at 435.

117. A lawyer at Boston University School of Medicine described some patients as "horribly mistreated" as a result of the decision. There were reports of doctors implanting cardiac pacemakers in brain-dead patients and, in a particularly egregious case, of a terminally ill woman being subjected to cardiac defibrillation seventy times in a twenty-four period until she finally died. Amos, *After Saikewicz: No-Fault Death*, 8 HASTINGS CENTER REP. 16, 18 (1978).

118. *Id.*

119. 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).

120. Justice Armstrong, writing for the *Dinnerstein* court, described "no-code" order thusly: "The terminology derives from the development in recent years, in acute care hospitals, of specialized 'teams' of doctors and nurses trained in the administration of cardiopulmonary resuscitative measures. If a patient goes into cardiac or respiratory arrest, the nurse in attendance causes a notice to be broadcast on the hospital's intercommunications system giving a code word and the room number. The members of the code team converge on the room immediately from other parts of the hospital. In the hospital in question, if the code is broadcast at night, all doctors then in the hospital for whatever reason are expected to respond to

ing conducted by the court, Dinnerstein was declared to be irreversibly terminally ill and in an essentially vegetative state.

Noting that resuscitation procedures are often highly intrusive, violent and painful, and where applied to patients like Dinnerstein merely served to prolong the act of dying, the court distinguished the *Saikewicz* situation:

This case does not offer a life-saving or life-prolonging treatment alternative within the meaning of the *Saikewicz* case. It presents a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the imminent passing of an irreversibly terminally ill patient in light of the patient's history and condition and the wishes of her family. That question is not one for judicial decision.¹²¹

Of course, the *Dinnerstein* opinion raises a new and difficult question: under what circumstances does a given treatment offer a cure of or meaningful relief from an illness and when is it merely life-prolonging? Under the *Dinnerstein* rationale, that decision is to be made by the physician, applying his/her best medical judgment.

Thus, *Dinnerstein* focuses on the nature of the treatment: if it is life-saving, if it offers a cure—or even a meaningful remission—it falls within the *Saikewicz* rule, and the court must decide after a full adversarial hearing whether it shall be withdrawn. On the other hand, if it is life-prolonging, in that it delays imminent death and, in effect, merely suspends the act of dying, *Saikewicz*-type proceedings are not required and the decision may be made by the physician in concert with the family.

This dichotomy, although not legally significant until *Dinnerstein*, has long been recognized in the physician-patient relationship. The *Quinlan* court observed that it is a fact of modern medical practice:

[P]hysicians distinguish between curing the ill and comforting and easing the dying: . . . they refuse to treat the curable as if they were dying or ought to die, and . . . they have sometimes refused to treat the hopeless and dying as if they were curable.¹²²

Medical commentators¹²³ hailed the *Dinnerstein* decision not only be-

the code. A "no-code" order entered in a patient's medical record instructs the nursing staff, as part of the attending physician's ongoing instructions to the nursing staff for the care of the patient, not to summon the code team in the event of cardiac or respiratory arrest. A no-code order is sometimes called ONTR (order not to resuscitate) (Rabkin, Gillerman & Rice, *Orders Not to Resuscitate*, 295 New Eng. J. Med. 364 (1976) or DRN (do not resuscitate) (*In re Quinlan*, 70 N.J. 10, 29, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976). [cited in original form].") *In re Dinnerstein*, 6 Mass. App. Ct. at 469, 380 N.E.2d at 136.

121. *Id.* at 139.

122. *In re Quinlan*, 70 N.J. 10, 47, 355 A.2d 647, 667, cert. denied, 429 U.S. 922 (1976).

123. See, e.g., *Clarification of the Saikewicz Decision*. MASS. MEDICAL SOCIETY NEWSLETTER, Vol. XVIII, No. 4, July-Aug. 1978.

Right to Die

cause it clarified *Saikewicz* and reduced the incidence of unnecessary litigation, but also because it displayed an awareness of the medical reality that doctors daily make decisions about whether to treat or withhold treatment, and that frequently those decisions have life or death implications.

In re Spring,¹²⁴ decided by the Massachusetts Supreme Court in early 1980, continued the *Dinnerstein* trend, further elaborating the distinctions between cases appropriate for court involvement and cases that should be resolved by the patient's family and physician without the necessity of judicial approval. Despite the presence of some disturbing and confusing language, the thrust of the opinion is in a positive direction—away from the insistence in *Saikewicz* upon judicial proceedings in all withdrawal-of-treatment cases involving incompetents, and toward a thoughtful, well-reasoned delineation of the circumstances under which court intervention is inappropriate.

While *Spring* reiterates the *Saikewicz* opinion that: "we disapprove shifting of the ultimate decision-making responsibility away from the duly established courts," the court nevertheless emphasizes several times in its opinion that neither *Saikewicz* nor *Spring* should "be taken to establish any requirement of prior judicial approval."¹²⁵

This confusion is ultimately resolved, since later in its opinion the court explains that what it means when it speaks of disapproving the shift of responsibility for treatment decisions away from the court is merely that *once* judicial proceedings have been instituted, the courts should retain jurisdiction to decide the ultimate questions. Thus, the *Spring* court said:

[W]e in no way disapprove the practice of committee review of decisions by members of a hospital staff. But private medical decisions must be made responsibly, subject to judicial scrutiny if good faith or due care is brought into question in subsequent litigation. . . . *This is true of medical decisions generally*, and is no less true of a decision to withhold medical treatment from an incompetent patient.¹²⁶

This is a surprising explanation of the meaning of *Saikewicz*. Whether the Massachusetts Supreme Judicial Court had really meant this when it wrote the *Saikewicz* opinion is not important, since it was not interpreted that way by the medico-legal community. In this sense, then, *Spring* represents an important advance for legal and medical practitioners in Massachusetts, since it reassured them that prior judicial ap-

124. 1979 Mass. Adv. Sh. 2469, 405 N.E. 2d 115 (1980).

125. 405 N.E. 2d at 120.

126. 405 N.E. 2d at 122 (emphasis added).

proval is not an automatic prerequisite for cessation or withdrawal of treatment from an incompetent patient.

The *Spring* court presented a number of factors that should be considered by the parties (physician, family, and hospital) when deciding whether judicial involvement is necessary or appropriate: the mental competence of the patient, the prognosis for recovery or meaningful remission, the nature of the treatment, including degree of invasion, possible side effects and risks, the wishes of the patient's family, the interests of third parties, and prevailing medical practice.

Most of these factors are familiar. Mental competence to make decisions about one's own treatment has been a paramount question in many cases where the patient's mental state has been an issue. The prospect of recovery has been a prominent factor in virtually all of the cases in this area. *Dinnerstein* first articulated its significance on the issue of whether judicial proceedings were appropriate. Degree of bodily invasion, non-interference with prevailing medical practice, and interests of third parties have also been significant factors in the application of the privacy balancing test in a number of cases.¹²⁷ But *Spring* was the first decision that cohesively delineated these factors as guidelines to the physician and family faced with decisions about treatment or non-treatment of a terminally ill incompetent patient—a great step forward, especially in light of its (unfortunately belated) clarification of the disturbing concluding language in the *Saikewicz* opinion. In light of *Spring*, physicians need no longer feel paralyzed when asked to withdraw treatment from a hopelessly ill patient in the absence of judicial authorization.

Although the *Spring* guidelines are well-reasoned and commendable in that they encourage respect for the wishes of the patient, they remain disappointing in two respects. First, the opinion fails to cite as a factor the prior wishes of an incompetent patient, which may be known to the physician or communicated by the family. Second, *Spring* fails, far more so than *Quinlan* did, to stress the importance of the family's wishes in the case of the incompetent patient. The repetitive posture of these cases—the family's request on behalf of the patient for termination of treatment is refused by the physician, necessitating the institution of what becomes extensive litigation in which the family's decision is ultimately vindicated—reflects the need for judicial articulation of the primacy of the family's role in decision-making for the incompetent patient.

127. See also *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1975); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978); *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E. 1232 (1979).

Right to Die

c. *The Family as Decision-Maker*

In re Quinlan,¹²⁸ decided by the New Jersey Supreme Court in 1975, was the first judicial decision to hold that the constitutional right of privacy is applicable to terminally ill patients who refuse life-prolonging treatment. The court displayed impressive foresight in *Quinlan*, its first and only opportunity to consider the issues, in that it managed to avoid the twin pitfalls of *Saikewicz*: it recognized the inherent undesirability of and potential harm resulting from excessive judicial involvement in treatment decisions for the incompetent patient, and it exhibited an awareness of and respect for existing medical practices, including the important problem of the physician's fear of liability. Finally, of leading decisions in the area, the *Quinlan* opinion placed the strongest emphasis upon the decision-making role of the family.

The New Jersey court recognized that treatment decisions are best made within the patient-doctor-family relationship. The court implicitly expressed the view, shared by the authors of this article, that in most cases a course of treatment should be determined jointly by the patient's physician and family. The caring family and the physician—unencumbered by fear of liability—are in a far better position than the court to decide upon a course of treatment that best reflects the wishes and needs of the patient. Where it appears that the family may not be acting unselfishly, and/or the physician in good faith disagrees with the family's views on treatment, judicial proceedings are not only available, but are usually inevitable. Thus the patient is afforded protection from the uncaring family or irresponsible doctor.

In the usual course of hospital practice, the physician and family jointly decide together that cessation of life-prolonging treatment is best for the terminally ill patient, and the matter thus never reaches the point of judicial involvement.¹²⁹ But, while few of the recent cases in this area resulted in litigation concerning a bona fide question as to the appropriate course of treatment,¹³⁰ a number of incompetent patients

128. On April 15, 1975, for reasons not entirely clear, Karen Quinlan ceased breathing for two 15 minute periods. After admission to the hospital she was diagnosed by physicians as being in a chronic persistent vegetative state and without cognitive function. The hospital maintained her on a respirator. When doctors refused to remove the respirator, her father instituted proceedings to be appointed her guardian with the express power to authorize discontinuance of extraordinary treatment. The lower court denied authorization for termination of life supporting apparatus and withheld letters of guardianship. The patient's father appealed. The Supreme Court held that he could exercise the right to privacy on her behalf, and that that right encompassed the right of an incompetent patient to effect termination of life-prolonging medical treatment. See *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1975).

129. Giancola, *The Discontinuation of "Extraordinary" Medical Treatment from a Terminal Patient*, 1980 MEDICAL TRIAL TECHNIQUE QUARTERLY 328 n.7.

130. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1978).

have become the subject of extensive litigation because the physician, while not necessarily disagreeing with the family's request to cease treatment, feared possible liability.

The *Quinlan* court, citing these concerns and recognizing that judicial involvement would be 'impossibly cumbersome,' rejected the approach (later associated with the *Saikewicz* case) of decision-making by adversarial court proceedings. It proposed as one possible alternative the utilization of hospital ethics committees—which would enable physicians, many of whom share the family's view that treatment should be terminated but are reluctant to comply with their wishes because of fear of possible liability, to seek a "second opinion" from the committee. If the committee concurs with the views of the family and physician, the physician is encouraged to proceed in accordance with his best medical judgment, without fear of liability. If, on the other hand, the ethics committee does not concur, the physician undoubtedly will refuse to comply with the family's request to cease treatment and litigation probably will result. The *Quinlan* court cited with approval the following description of the ethics committee approach by a commentator who advocates its use:

It diffuses the responsibility for making these judgments. Many physicians, in many circumstances, would welcome this sharing of responsibility. I believe that such an entity could lend itself well to an assumption of a legal status which would allow courses of action not now undertaken because of the concern for liability.¹³¹

One practical problem with the ethics committee approach is that the fear of liability may be just as prevalent among committee members who are acting as agents of the hospital as it is for the individual physician. It seems probable, though, that the simple act of diffusing the decision-making responsibility should, to some extent, ease the concern for liability.

Another potential problem is that although the court's suggestion may encourage the liability-conscious physician to consult the hospital ethics committee where he/she might otherwise simply have refused to honor the wishes of the patient's family, the physician who, pre-*Quinlan*, would have abided by the family's request, may now feel compelled to take the additional step of consulting the ethics committee. Language in the *Quinlan* decision suggests that the ethics committee is viewed by the court as an advisory body available to the physician if he/she chooses to utilize it; other language, however, might lead a physician or

131. 70 N.J. at 49-50, 355 A.2d at 669, citing Teel, *A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975).

Right to Die

legal advisor to conclude that the ethics committee must be consulted in all cases prior to any cessation of life-prolonging treatment.

d. *Matter of Storar: An Anomalous Decision—The New York Approach*

On March 31, 1981, the New York Court of Appeals handed down a startling and disturbing opinion in companion cases entitled *Soper v. Storar* and *Eichner v. Dillon*.¹³² Father Eichner had initiated proceedings in the trial court seeking disconnection of the respirator attached to Brother Fox, an 83-year-old fellow member of the Society of Mary who had lapsed into a chronic vegetative state during a routine hernia operation. In the *Storar* case, the patient's mother (and legal guardian) had withdrawn her consent to blood transfusions that were being administered periodically to her 52-year-old profoundly retarded son, who was suffering from terminal cancer of the bladder. The director of the state facility in which Mr. Storar resided petitioned for a court order authorizing the continuance of the blood transfusions.

At the trial level, Eichner's petition for discontinuance of treatment was granted, while the application for authorization to treat Storar was denied. Both decisions were upheld by the appellate division. Both patients had already died by the time the New York Court of Appeals, New York's highest Court, rendered its decision. In *Eichner*, the court sanctioned cessation of treatment while in *Storar* it was forbidden. The holding in the *Eichner* portion — that Brother Fox could be removed from the respirator — is consistent with prevailing case law, although the legal reasoning is quite different. The court declined to join *Quinlan* and its progeny, which have held that the constitutional right of privacy is applicable to compulsory treatment cases, describing the issue as "disputed"—one that the U.S. Supreme Court has repeatedly declined to consider. In any event, the court reasoned, since Brother Fox was entitled under common-law principles to the relief he sought, there was no necessity to resolve or even reach the constitutional issue.¹³³

The *Storar* portion of the court's decision represents the first appellate judicial decision of the recent past to order treatment against the wishes of the patient's family or guardian. As in the *Eichner* portion of its opinion, the court does not find Storar's medical condition or prognosis for recovery to be legally significant. To the degree that it discusses these factors, its findings ignore or contradict those contained in the trial record.¹³⁴ It makes the narrow finding that the transfusions themselves

132. 52 N.Y.2d 363, 420 N.E.2d 64 (1981).

133. *Id.* at 376-377, 420 N.E.2d at 70.

134. For example, the Court of Appeals declared that without the treatments, Storar faced the risk of an earlier death. The trial court found that "Storar has a life expectancy of

"did not involve excessive pain," but ignores the trial court's findings that as a result of the transfusions Storar's sensitivity to the pain caused by his cancerous condition was significantly increased and, worse, that the pain was becoming progressively more intense. Nor is there any mention of the finding that Storar had to be sedated and physically restrained in order for the treatment to be administered. Finally, no reference is made to the trial court's finding that Storar's mother "had provided more love, personal care, and affection for John than any other person or institution, and was closer to feeling what John was feeling than anyone else; that his best interests were of crucial importance to her; that in his mother's opinion, it would have been in John's best interests to discontinue the transfusions, and she believes that he would wish to have them stopped."¹³⁵

(1) *Privacy*

As we will see in a moment, the court's holding in *Storar* rested upon its conclusion that under the New York common law, an incompetent must receive adequate medical treatment under all circumstances except where the patient, while competent, expresses wishes to the contrary. Having done so, it is puzzling that the court did not then turn to the issue of whether or not the constitutional right of privacy encompasses a decision to decline life-prolonging treatment, and if so, whether Storar's right to privacy could be invoked on his behalf by his mother. This is particularly surprising in light of the fact that the court raised that very question in its consideration of Eichner's claim and concluded that no resolution was necessary since it was already willing to authorize the cessation of treatment in the case of Brother Fox.

(2) *Storar and the Common Law*

The New York Court concluded that Storar had not and could not have expressed a wish, while competent, that treatment be discontinued. As a result, the Court believed that it could not, under New York common-law, authorize the cessation of blood transfusions. One basis for so holding was the Court's rejection of the doctrine of substituted judgment, a concept frequently utilized in cases involving incompetents in which someone else—often the court or a family member—makes a decision on the incompetent's behalf which attempts to approximate as nearly as possible the decision the incompetent himself would have made, had he been able to do so. The court based its determination that the substituted judgment doctrine was inapplicable to *Storar* on its con-

from two to six months regardless of whether the blood transfusions are continued or not." *Id.* at 389, 420 N.E.2d at 78 (Jones, J., dissenting in part).

135. 52 N.Y.2d at 391, 420 N.E.2d at 78-79 (Jones, J., dissenting in part).

Right to Die

clusion that, since the patient's mental age was that of an infant, it would be "unrealistic to attempt to determine whether he would want to continue potentially life-prolonging treatment if he were competent. . . . [That would be like] asking whether 'if it snowed all summer would it then be winter?'"¹³⁶

This view is contrary to that of other jurisdictions. The leading cases—*Quinlan*, *Saikewicz*, *Severns*—and a lower court decision¹³⁷ have all embraced the substituted judgment doctrine, concluding that to do otherwise would compel terminally ill incompetent patients to submit to life-prolonging treatment that a competent patient would be permitted to decline. Citing the modern legal trend to grant to incompetents the same rights as others, the Massachusetts court declared in its *Saikewicz*¹³⁸ decision: "To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decide is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality."¹³⁹

Having rejected the substituted judgment doctrine, the New York court turned next to its *parens patriae* duty to protect the welfare of incompetents. It makes a blanket assertion that "the courts may not permit a parent to deny a child all treatment for a condition which threatens his life." The court cites its 1979 decision in a case entitled *In re Hofbauer*,¹⁴⁰ as support for this proposition. Yet in that case, it had held that "the most significant factor in determining whether a child is being deprived of adequate medical care . . . is whether the parents have provided an acceptable course of medical treatment for their child *in light of all the surrounding circumstances*."¹⁴¹ The Court appears to be saying that there are never circumstances in which an acceptable course of treatment is not to treat at all. If so, it is at odds not only with other courts, but with prevailing medical practice which, as the *Quinlan* court observed, "distinguishes between curing the sick and comforting the dying."¹⁴²

However, other language in the opinion suggests that the *Storar* court

136. 52 N.Y.2d at 380, 420 N.E.2d at 72-73.

137. See, e.g., *In re Benjamin, C.*, No. J-914419 (Sup. Ct. L.A. Cty., Feb. 15, 1979) (unreported juvenile probate case).

138. Because it also involved a profoundly retarded patient, the *Saikewicz* analysis is most directly at odds with that of *Storar*. Citing several factors—the treatment's very unpleasant side effects; the patient's slim chances for remission; and his inability to comprehend the purpose for the treatments, which caused him to experience even greater fear and distress—the Massachusetts court concluded that Saikewicz, had he been competent to do so, would himself have chosen to forego treatment. See 373 Mass. at 753-755, 370 N.E.2d at 431-432.

139. 373 Mass. at 747, 370 N.E.2d at 428. For an extensive discussion of the substituted judgment doctrine see 373 Mass. at 745-755, 370 N.E.2d at 427-432.

140. 47 N.Y.2d 648, 419 N.Y.S.2d 936, 393 N.E.2d 1009 (N.Y. 1979).

141. *Id.* at 656, 419 N.Y.S.2d at 940-941, 393 N.E.2d at 1014.

142. *In re Quinlan*, 70 N.J. 10, 47, 355 A.2d 647, 667.

does not intend to go quite this far. Having concluded that the treatment at issue was not particularly painful, the court suggests in a footnote¹⁴³ that the result might have been different had it found that *Storar* was in great pain. It is difficult to reconcile the language contained in this footnote with the legal analysis the court provides. If the *Storar* court absolutely believes that "courts may not permit a parent to deny a child all treatment for a condition which threatens his life,"¹⁴⁴ then it is not clear how degree of pain can ever alter the result.

The real problem seems to lie with the court's failure to draw any distinction between the administration of treatment to a gravely ill incompetent who can be restored to full health, and compelling the same treatment in the case of a patient in John *Storar's* medical condition. One can anticipate that, much like the Massachusetts experience after *Saikewicz*, subsequent decisions by the New York Court of Appeals will modify the absolutist position apparently taken in *Storar*.

(3) *Conclusion*

The *Storar* opinion concludes with these words: "If it is desirable to enlarge the role of the courts in cases involving discontinuance of life-sustaining treatment for incompetents . . . the change should come from the Legislature."¹⁴⁵ Another court has expressed a similar sentiment, although only New York denies relief to the incompetent in the absence of legislation.¹⁴⁶

In New York, then, the desirability of appropriate legislation is apparent. But there is a pressing need for uniform nationwide legislation, especially in view of the number of physicians who continue to insist upon aggressive treatment regardless of the patient's condition and wishes. Such legislation clarifies the roles of all parties and protects the patients from the delays and vagaries inherent in judicial proceedings of this nature. Uniform legislation is needed in every state, in light of the reluctance exhibited by a number of courts to establish guidelines and detailed rules and procedures for the resolution of similar cases in the future, and because of the general haphazardness inherent in judicial resolution of issues. As the Florida Supreme Court commented in *Perlmutter*:

Because the issue with all its ramifications is fraught with complexity and

143. In footnote 7 of its opinion, the court states: "Whether the presence or absence of excessive pain would be determinative with respect to the continuation of life-sustaining measures need not be reached under the facts of this case." *In re Storar*, 52 N.Y.2d 563, 381, n.7, 420 N.E.2d 64, 73, n. 7.

144. 52 N.Y.2d at 381, 420 N.E.2d at 73.

145. *Id.* at 382-383, 420 N.E.2d at 74.

146. *See, e.g.,* *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1981).

Right to Die

encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type of issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.¹⁴⁷

C. Legislation

Our discussion of the right to die thus far has focused upon the recent case law and related commentary on issues raised by the cases. A full treatment of the subject requires some mention of the scope and impact of the "living will" statutes and other similar legislative proposals, especially in light of the significant legislative activity in this area in recent years.

These statutes, in various forms, have been enacted in fourteen jurisdictions.¹⁴⁸ The fourteen statutes already on the books became law primarily because of continued public awareness and concern with the issue, including that of legislators who have had personal experiences with death and dying. These efforts will continue, with new legislation the undoubted result.

In considering the legal impact of legislation in this area, we will briefly discuss the role that state legislation has played in relation to medical practice and then contrast "living will" legislation with other types of medico-legal statutes. We will then offer an analysis of the current statutory law, with particular emphasis upon the problems of the incompetent patient.

1. Increasing Regulation of Medical Practice

State legislatures have passed many laws regulating the physician's

147. *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So. 2d 359, 360 (Fla. 1980).

148. Alabama: Natural Death Act, ALA. CODE §§ 22-8A-1 to -10 (Cum. Supp. 1982); Arkansas: Death with Dignity, ARK. STAT. ANN. §§ 82-3801 to -3804 (Cum. Supp. 1981); California: Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Cum. Supp. 1982); District of Columbia: Natural Death Act, D.C. LAW 4-69 (Not codified since only enacted as of the close of business on Feb. 24, 1982); Idaho: Natural Death Act, IDAHO CODE §§ 39-4501 to -4508 (Cum. Supp. 1982); Kansas: Natural Death Act, KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1980); Nevada: Withholding or Withdrawal of Life-sustaining Procedures, NEV. REV. STAT. §§ 4499-540 to 690 (1979); New Mexico: Right to Die Act, N.M. STAT. ANN. §§ 24-7-1 to -11 (1981); North Carolina: Right to Natural Death; Brain Death, N.C. GEN. STAT. §§ 90-320 to -323 (1981); Oregon: Rights with Respect to Terminal Illness, OR. REV. STAT. §§ 97.050 to .090 (1979); Texas: Natural Death Act, TEX. REV. CIV. STAT. ANN. art. 4590h §§ 1 to 11 (Vernon Cum. Supp. 1982-1983); Vermont: Death with Dignity, as of April 24, 1982; Washington: Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010 to .122.905 (West Cum. Supp. 1982).

conduct in cases where fundamental interests are involved. For example, doctors are now required by law to keep scrupulous records and notify the proper authorities whenever they witness a birth or death,¹⁴⁹ treat a case of contagious disease,¹⁵⁰ or suspect a case of child abuse or neglect.¹⁵¹ Many states have passed statutes defining the nature and content of disclosure required where surgery or emergency procedures are medically indicated.¹⁵² In states where "good samaritan" statutes are on the books, the physician is encouraged to render aid at the scene of an accident or other emergency, without fear of liability.¹⁵³

These statutes are legislative responses to particularized societal needs and they all make some attempt to supply needed codification and enforcement of the fiduciary obligation of the physician in critical situations. Perhaps the most striking example of such a codification may be found in the Uniform Anatomical Gift Act, a recently proposed statutory scheme governing organ transplants, now law in 50 states and the District of Columbia.¹⁵⁴

2. *Current Legislation*

Thirteen jurisdictions have undertaken a similar responsibility with respect to terminally ill patients. These statutes, like others previously mentioned, alter the traditional common-law status of the physician-patient relationship by codifying and enforcing the physician's fiduciary obligation to his patient and society at a crucial moment in the patient's life. There is no other time in life when the patient's wishes, desires, comfort and dignity are more paramount than when he or she is about to die. Although cold indifference shown by a physician at such a time might not be actionable malpractice, it is clear that a doctor who does not seek to comfort the patient during his/her last moments breaches his fiduciary duty to the patient and the trust placed in him by society. The rote, mindless administration of death-prolonging "extraordinary" medical measures to the dying patient is nothing less than cold indifference shown by a physician and hospital to the patient's needs and is arguably a breach of the physician's and hospital's duty in that regard.

Living will statutes, like the Anatomical Gift Acts, serve evidentiary,

149. See, e.g., N.J. STAT. ANN. § 26:8-30 (West Supp. 1981).

150. See, e.g., N.J. STAT. ANN. §§ 26:4-15 to 4-26 (West 1964 and Supp. 1982).

151. See, e.g., N.J. STAT. ANN. §§ 9:6-8.8 to 6-20 (West 1976 and Supp. 1981).

152. See, e.g., PA. STAT. ANN. § 40:1301.103 (Purdon Supp. 1982); N.Y., PUB. HEALTH LAW § 2805-d (McKinney Supp. 1980-1981); OHIO REV. CODE ANN. § 2317.54 (Page 1981). One study has asserted that passage of these statutes was a direct response by state legislatures to the "medical malpractice crisis" of the mid-1970's. See Meisel and Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. PITT. L. REV. 407, 410 (1980).

153. See, e.g., N.J. STAT. ANN. §§ 2A: 62A-1 to A-2 (West Supp. 1981); N.Y. EDUC. LAW § 6527 (McKinney 1972 and Supp. 1981).

154. UNIFORM ANATOMICAL GIFT ACT, §§ 1-7, 8 U.L.A. 15-44 (1972 and Supp. 1982).

Right to Die

and protective functions for the patient, family, doctor, and the community at a crucial time when the doctor's fiduciary obligation is subject to influence from many directions. Typically, each state's statute allows for a written directive to be executed by the patient before at least two witnesses while he/she is competent, directing the attending physician in the event of terminal illness to conduct the course of treatment in a particular manner. All of the statutes, except that in Arkansas, require a pre-withdrawal diagnosis of terminal illness by a physician. Ten of the statutes require some certifiable record of the diagnosis to be made after mandatory consultation with one or more other physicians.¹⁵⁵

The directive, put simply, is nothing more than a written memorialization of the patient's instruction to his/her doctor. It defines the nature and extent of the patient's consent to medical treatment and it allows for the specification of various treatment alternatives in the event of certain foreseeable complications. The document's contents can be pondered and debated at a time, hopefully, when the patient is not racked with pain or heavily sedated. A living will can serve as a definitive evidence of a patient's prior wishes, removing any doubt in the minds of those who might question the representations of next of kin. Perhaps the most important benefit to be derived from the living will is its ability to eliminate costly and time consuming litigation. It is true that those who have been incompetent for all of their lives will never be able to execute a living will. It should be noted, however, that five out of seven plaintiffs seeking termination whose cases have reached the highest state courts were people who had been competent prior to the onset of the terminal illness.¹⁵⁶ Binding legislation and the existence of a valid directive from the patient probably would have eliminated litigation in each of those five cases. Curiously, two states, North Carolina and Nevada, do not require compliance with the directive by the physician, but rather allow him to consider the directive as an advisory communication from the patient, to be considered in light of all the surrounding circumstances.¹⁵⁷ Statutes which do make such a directive binding on a physician fall into two groups: those requiring execution or re-execution after a diagnosis of terminal illness has been entered in the medical record,¹⁵⁸ and those declaring the directive to be binding regardless of when the

155. Idaho allows certification by one doctor alone. See IDAHO CODE § 39-4504 (1982).

156. See, e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1975), cert. denied, 429 U.S. 922 (1976); *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So. 2d 359 (Fla. 1980); *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1981); *In re Spring*, 1979 Mass. App. Adv. Sh. 2469, 399 N.E.2d 493, *rev'd*, 405 N.E. 2d 114 (Mass. 1980); *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (App. Div. 1980), *modified*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

157. NEV. REV. STAT. § 449.640 (1979); N.C. GEN. STAT. § 90-321(b) (1981).

158. The states with such statutes include California, Idaho, Oregon, and Texas.

period of terminal illness begins.¹⁵⁹

a. *Incompetent Patients*

The distinction between statutes making the directive binding at any time and those requiring re-execution after terminal diagnosis becomes important when consideration is given to the plight of the incompetent patient. Those statutes which require re-execution after terminal diagnosis tend to be unduly restrictive because they require the patient to be competent at the time of re-execution. Thus, if a 30 year-old wife and mother executes a living will on July 1, 1978 and three years later is involved in an automobile accident which leaves her in a persistent vegetative state, the doctor would not be statutorily bound to honor the previously executed directive because the patient is not competent to re-execute it. Under Oregon and Idaho law, there is no statutory authority for withdrawal of medical treatment in these circumstances. The Texas and California legislatures seemed to recognize the problem and attempted a solution.

Texas' Natural Death Act provides:

If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently re-executed the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the affected family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician justifies effectuating the directive. No physician, and no health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection.¹⁶⁰

Section 7191(c) of the California Natural Death Act¹⁶¹ is exactly the same. Apparently, physicians in California and Texas may, if the "totality of circumstances" justifies it, give effect to a directive even though the patient is unable to re-execute it after the onset of the terminal condition. Despite the ambiguity of these words, this provision does offer some measure of protection for patients who become incompetent and thus unable to re-execute the document. Thus, in California and Texas, the living will that has not been re-executed becomes an advisory communication, much like those sanctioned by North Carolina and Nevada.

159. The states with such statutes include New Mexico, Arkansas, Washington, Kansas, and Alabama.

160. Natural Death Act, TEX. REV. CIV. STAT. ANN., art. 4590h, § 7(c) (Vernon Cum. Supp. 1982-1983).

161. Natural Death Act, CAL. HEALTH & SAFETY CODE, §§ 7185 to 7195 (West Cum. Supp. 1980).

Right to Die

Perhaps the most far reaching of the death with dignity laws is North Carolina's statutory scheme. Originally passed on June 29, 1977, it gives coverage to the concept of brain death as well as legitimating the use of the living will. The statute follows the general format found in most other states—two unrelated witnesses are required, the terminal diagnosis must be confirmed by a second physician; a suggested form of directive is included, as well as forms for acknowledgment by witnesses. The directive can be executed at any time. Doctors who comply with such directives are immune from civil or criminal liability.

Section 90-322 of the North Carolina statute¹⁶² was amended, effective May 30, 1979, to allow withdrawal of extraordinary care even in the absence of a written declaration. If the patient is (a) comatose, (b) not reasonably expected to return to a cognitive sapient state, (c) incurable, and (d) terminal, physicians in North Carolina *may* discontinue life support systems at the request of spouse, guardian, or a majority of relatives of the first degree, in that order. A majority of the three-physician committee must confirm the attending physician's diagnosis before withdrawal takes place.

This procedure is a significant legislative step which will clearly assist many patients and their doctors in reaching a decision. It is unreasonable to expect every patient in North Carolina to see a doctor or lawyer and execute a living will. In most states, even those with right-to-die legislation, the patient without a living will might suffer for an undetermined amount of time, or, if withdrawal is effected, the physician may wonder if he/she will be sued by some disgruntled relative or charged by a zealous prosecutor. The North Carolina procedure substantially reduces the likelihood of prolonged suffering and eliminates any fear of liability on the part of the physician.

Section 90-322 should, therefore, act to eliminate litigation on behalf of comatose patients in situations similar to that of Karen Quinlan. One of the questions facing legislators in those states considering living will legislation is whether court intervention should be required in all cases involving incompetents. This question is of particular importance where the patient has not executed a declaration or where there is no strong evidence of prior wishes. Most courts, when confronted with an incompetent, unconscious patient requesting termination of care through parent or guardian, will, as did the *Quinlan*, *Saikewicz*, and *Eichner* courts, engage in a fairly extensive fact finding and appellate process, often lasting several years. Ultimately, in most of the recent cases, the patient's right to die was upheld. The North Carolina proce-

162. Brain Death, N.C. GEN. STAT. §§ 90-322 (1981).

dures is less costly, less time consuming, and will ultimately prevent a good deal of needless suffering.

Although the North Carolina statute substantially codifies the suggestions made by the *Quinlan* court and allows the physician to act in accordance with family wishes and accepted medical practice without fear of liability, it still suffers from infirmities. There is no provision for the trial and punishment of those who falsely execute, alter, or otherwise tamper with a living will. The directive is advisory only. The doctor is not bound to follow it. Paradoxically, the attending doctor is allowed to terminate extraordinary care, at his "discretion," if no family is "available" to make the decision.

What kind of discretion should we allow the physician in these circumstances? In our view, the lack of family situation presents the courts with the most vexing and difficult cases. Should physicians be entrusted with this kind of authority? Is the concurrence of two other physicians enough to validate this decision? What is meant by the word "available?" A physician, acting in compliance with the North Carolina law, would be well advised to thoroughly document his search for "available" family members before determining to discontinue extraordinary care. The statute is barely four years old. It will be several years before a significant number of living wills are disseminated throughout the state. Use of the procedure outlined in Sec. 90-322 will eliminate a significant amount of litigation and facilitate the medical profession's acceptance and orderly implementation of the wishes of patients and their families.

New Mexico, Washington, Kansas and Arkansas permit effectuation of living wills no matter when they are executed, provided the patient is shown to be terminally ill. Generally, under this formulation, we would expect that patients who had executed a directive and then fell comatose as a result of sudden terminal illness or injury would be protected and their wishes honored. This will be a tremendous boon to post-directive incompetent patients who have previously signed living wills. The directive is binding under all circumstances and must be followed or the patient transferred to another physician.

b. *Minors*

The most interesting feature of the New Mexico statute is its provision allowing execution of a document for the benefit of a terminally ill minor.¹⁶³ The act permits the minor's spouse, if adult, or if there is no adult spouse, then either parent or guardian, to execute a directive, pro-

163. Right to Die Act, N.M. STAT. ANN. § 24-7-4 (1978).

Right to Die

vided the minor has been certified to be terminally ill. The declarant is required to petition the local district court for "certification" of the document as well. The statute sets out very few procedural guidelines and, apparently, the court proceeding is similar to that undertaken by courts when probating a testamentary will. Little discretion is given to the trial judge; the court's only task is to grant certification, if it is "satisfied that all requirements of the Right To Die Act have been satisfied, that the document was executed in good faith, and that the certification of the terminal illness was in good faith"164 The certification of terminal illness must appear on the face of the document.

Only the state of Arkansas has enacted a similar provision, and New Mexico, like Arkansas, has apparently not had any problem in implementing the procedure. New Mexico does not impose a waiting period prior to effectuation. Therefore, any New Mexico directive can be effectuated any time after execution, and, in the case of a minor, at any time after certification by the district court.

The New Mexico statute also provides that a spouse, parent, or guardian of a minor may not execute a document on his/her behalf where the declarant "has actual notice of contrary indications by the [terminally ill] minor . . . or . . . he has actual notice of opposition by either another parent or guardian or a spouse"165 Any declarant who executes a document after receiving actual notice of contrary intent from the minor or opposition from a parent or guardian is declared to be guilty of a second degree felony.

These penal provisions have real teeth and are obviously designed to make a person who executes a directive for a minor act carefully and prudently. We commend the New Mexico statutory provisions concerning minors to the other states; they strike a careful balance between the rights of parents of terminally ill minor children and the right of the state, as *parens patriae*, to insure protection for the welfare of its minor citizens.

c. *Physician Immunity*

All of the Right-To-Die statutes immunize the physician from civil and criminal liability if he or she, in good faith, follows the dictates of the patient's directive authorizing the termination of treatment. The immunity provisions of these statutes are, in many respects, far more important than other items since they encourage physicians to act in situations where the fear of liability might be inhibiting. Elimination of

164. Right to Die Act, N.M. STAT. ANN. § 24-7-4(D) (1978).

165. Right to Die Act, N.M. STAT. ANN. § 24-7-4(B) (1-2) (1978).

the risk of liability promotes the probability that the patient's directions will be followed in appropriate circumstances.

Unfortunately, the immunity provisions vary in scope and specificity from state to state. The most interesting is California's scheme. Section 7190 grants immunity to any physician, health facility, or licensed health professional who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of the act.

Standing alone, Section 7190 offers the same safe harbor as do all of the other subsequently enacted statutes. However, the California act goes further. Section 7191(b) provides:

If the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician . . . shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subdivision. A failure by a physician to effectuate the directive of a qualified patient pursuant to this division shall constitute unprofessional conduct if the physician refuses to make the necessary arrangements, or fails to take the necessary steps, to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.¹⁶⁶

The practical effect of this provision is to prohibit the institution of a criminal action or civil litigation for damages against a physician who refuses to effectuate a binding directive or to transfer a patient to another physician so that the directive might be carried out. Although such conduct is deemed to be unprofessional, the only sanction available is through the professional licensing boards. In this respect, dying patients are deprived of a common law remedy they would otherwise retain; the physician who ignores the law in California now is no longer liable for conduct which would have heretofore rendered him liable in damages.

Unlike the California statute, New Mexico does not provide its physicians with blanket immunity from civil and criminal liability. Rather, Section 7 of the New Mexico statute confers a presumption of good faith, provided the physician relies on a properly executed document with no actual notice of revocation or contrary indication. The statute expressly allows anyone to allege and prove, presumably in a civil action, that the physician's actions violated the "standard of reasonable professional care and judgment under the circumstances."¹⁶⁷

These provisions grant the physician the familiar "qualified immu-

166. Natural Death Act, CAL. HEALTH & SAFETY CODE, § 7191(b) (West Cum. Supp. 1980).

167. Right to Die Act, N.M. STAT. ANN. § 24-7-1 to 24-7-11 (1978).

Right to Die

nity" from civil liability frequently accorded public officials who are required to make a good faith effort to discharge certain duties arising under the case law, statutes, codes and ordinances.¹⁶⁸ In our view, this is a much more sensible and realistic way to handle the immunity problem. The scheme reassures the competent physician and encourages him to act, while affording the family some protection against misdiagnosis or worse, actions taken in bad faith by the physician. The New Mexico legislature has again achieved a balancing of two strong competing interests in a fashion which does not elevate the position of any particular actor.

Most of the other statutory immunity provisions fall somewhere between those of California and New Mexico. Nevada, Texas and Washington immunize the physician from criminal or civil liability "for failing to effectuate the directive of a 'qualified patient.'" On the other hand, Oregon's Right to Die Act¹⁶⁹, while immunizing the physician who in good faith participates in withdrawal or withholding of treatment, provides that nothing in the act "shall impair or supercede any legal right or *legal responsibility* which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner" (emphasis added). Presumably, if a living will is properly executed, witnessed, and delivered to a physician in Oregon, he or she would not have the luxury to ignore it.

Idaho's Natural Death Act, while not imposing a statutory duty to transfer, provides:

This chapter shall have no effect or be in any manner construed to apply to persons not executing a directive pursuant to this chapter nor shall it in any manner affect the rights of any such persons or of others acting for or on behalf of such persons to give or refuse to give consent or withhold consent for any medical care, neither shall this chapter be construed to affect chapter 43, title 39, Idaho Code, in any manner.¹⁷⁰

Chapter 43, title 39 of the Idaho Code defines the parameters of the informed consent doctrine and codifies the physician's traditional common law responsibilities under the doctrine. The Idaho law is therefore quite similar to Oregon's in that the common law action sounding in battery for failure to obtain consent is preserved.

The Kansas and North Carolina statutes are silent on the question of preservation of the patient's common law rights. Kansas, while granting immunity to the physician who participates, expressly deems a refusal to

168. See generally *Pierson v. Ray*, 386 U.S. 547 (1967); *Wood v. Strickland*, 420 U.S. 308 (1975).

169. Right with Respect to Terminal Illness, OR. REV. STAT. § 97.085(2).

170. Natural Death Act, IDAHO CODE § 39-4508(1).

act to be unprofessional conduct under the Kansas Medical Licensing Acts. Nothing else is said.¹⁷¹ North Carolina's silence on the issue is somewhat less significant by virtue of the fact that a directive in that state is no more than an advisory communication in any case.¹⁷²

In sum, it is apparent that the statutory immunity provisions now in place in at least five of the jurisdictions under consideration are in need of redrafting. It could be argued that the results reached after analysis of the effect of these provisions are substantially in accord with the intent of the various legislatures. We have not, however, discovered any statement which would lead one to believe that the legislatures intended to immunize physicians from the moment they received a living will no matter what their course of action was. This obviously would be an untenable situation. It would seem that the legislative purpose in authorizing immunity for those physicians who fail to act was to prevent the legal condemnation of those who, for whatever reasons, could not in good conscience terminate life-prolonging care. In spite of statutorily mandated procedures requiring transfer of the patient, the use of ambiguous and truncated language on the question of immunity causes five of the statutes in question to reach beyond the intended result, thereby encouraging behavior contrary to the announced public policy of the states.

III. *Conclusion*

There is a great need for death with dignity legislation in every jurisdiction where advanced life-prolonging medical technology is available to hospitals and practicing physicians. This need clearly justifies the passage and implementation of death with dignity laws even in those jurisdictions where problems of statutory interpretation might someday cause occasional litigation, confusion or delay.

As we have previously noted, legislatures have begun to respond to the societal need for codification of the responsibilities of physicians in a number of areas. Many of these statutes take the form of uniform laws, drafted and approved by the National Conference of Commissioners on Uniform State Laws.

The reasons for uniform treatment of the subject of determination of death are obvious. Disparate and inconsistent statutory definitions of death are bound to lead to confusion among doctors and ill-advised transportation of patients from state to state.

171. Natural Death Act, KAN. STAT. ANN. §§ 65-28, 101 to 65-28,109 (1980).

172. Right to Natural Death, Brain Death, N.C. GEN. STAT. §§ 90-320 to 90-323 (1981).

Right to Die

The same considerations apply to death with dignity laws, although they deal with a substantively different question, the right to die rather than the question of the existence of death. The technology employed to sustain life is generally uniform throughout the country. It is the standard of medical treatment of the terminally ill which varies from state to state. These variations in medical practice may, to some extent, be influenced by the nature and content of living will legislation in those various states. Since the technology is uniform, and improving everyday, it would seem that uniform legislation, incorporating all of the best features of the various state laws, is probably the way of the future.

Any bill approved by a state legislature should clearly define the class of persons within the purview of the statute. It should require certification of terminal illness by two physicians and make the executed directive binding on the attending physician from the moment the diagnosis of terminal illness is placed in the medical chart.

All living will statutes, and any uniform bill proposed, should expressly make liable, in law and equity, the physician who refuses to honor a valid directive or transfer a qualified patient. New Mexico's court certification procedure for declarations on behalf of infants can easily be broadened and made applicable to any incompetent patient for whom there is no hope. New Mexico's concept of the "contrary indication," expressed by the patient or any close relative, can also be incorporated in uniform legislation implementing procedures for court certification of directives executed on behalf of adult incurable incompetents. Penalties for forgery, unauthorized defacement or alteration, and fraud should also be incorporated in any uniform legislation.

Uniform legislation mandating definite and regularized procedures involving termination or withholding of treatment of the terminally ill will certainly reduce patient suffering, family expense and physician anxiety in any state adopting such a statute. Indeed, uniform legislation has eliminated a number of problems in several other areas where medico-legal matters have involved issues of national significance.