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PRIVACY AND THE RIGHT TO DIE

Peter J. Riga*

Literature relating to the ethical, psychiatric and legal aspects of euthanasia, already voluminous, continues to grow. It is important for lawyers to be prepared for the arguments which will arise from these core questions, so that they may effectively lead society through reasoned arguments, rather than naked emotion, to solutions which will respect the rights of all concerned. The interests of doctors, hospitals, patients, next of kin and the state must be developed and defined before the application of law may be made. The present context of the arguments concerning the "right to die" and privacy must be examined, therefore, before concrete cases may be analyzed.

I. THE COMMON LAW

At common law, one who assisted another in committing suicide, whether by furnishing the means to do so or otherwise, was guilty of murder.1 Today, while no American jurisdiction considers suicide a crime, every modern legal system labels euthanasia as criminal.2 Few punish euthanasia as severely as the Anglo-American system. This emphasis was due to the influence of Christianity, which regarded life as sacred and inalienable. The criminal law reflected this philosophy, defining murder as the killing of another human being with malice aforethought "no matter how kindly the motive."3 As long as the killing is done with malice, a term which denotes the intent to kill or cause serious bodily harm, the crime is murder. The California Supreme Court has observed that "one

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3 State v. Ehlers, 98 N.J.L. 236, 241, 119 A. 15, 17 (1922) (defendant found guilty of murder for shooting son although state had no evidence of motive).
who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief."

Malice, therefore, is a significant concept, accepted as a datum in the American system of law. One of the first cases involving euthanasia clearly showed this. In *People v. Kirby*, the defense counsel argued that the defendant, who had drowned his daughter and stepson "because he thought it better for them to go into eternity than to stop in this world," could not be convicted of murder because "there was no evidence of malice against the children, but, on the contrary, it appeared he was much attached to them." The court, rejecting this interpretation of malice, stated that "[e]very willful and intentional taking [of] the life of a human being, without a justifiable cause, is murder, if done with deliberation and not in the heat of passion, and legal malice is always implied in such cases." This common law absolutist view did not recognize motive as a defense to a charge of murder:

If the proved facts established that the defendant in fact did the killing willfully, that is, with intent to kill . . . and as the result of premeditation and deliberation, thereby implying preconsideration and determination, there is murder in the first degree, no matter what [the] defendant's motive may have been . . . .

Furthermore, even the consent of the victim was no defense to the charge of murder under the common law. Thus, since the factors which distinguished euthanasia from other deliberate acts of killing—a humanitarian motive and consent of the victim—were not recognized at common law, euthanasia was not deemed an exception to a murder charge.

**Case Law**

One of the first reported cases which involved euthanasia was *People v. Roberts*, wherein the defendant had helped his incurably ill wife to commit suicide by mixing her a poison potion. The defense argued that since suicide was not an offense, the husband could not be charged as an accessory. While the court found that the husband was not an accessory,

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* Id.
* 98 N.J.L. at 240, 119 A. at 17.
* Turner v. State, 119 Tenn. 663, 671, 108 S.W. 1139, 1141 (1907) (guilty of first degree murder for shooting woman who stated that she wanted to die with the defendant).
he was found guilty of the statutory offense of administering poison.\textsuperscript{10}

The leading federal case, \textit{Repouille v. United States},\textsuperscript{11} involved an immigrant who had been denied citizenship on the ground that he was not of “good moral character.” Mr. Repouille had deliberately put his thirteen year old son to death with chloroform. The son was blind, mute, severely deformed and had suffered a serious brain injury at birth. The child, therefore, was unable to feed himself, voided involuntarily and spent his entire life in a crib.\textsuperscript{12} After the killing, Repouille was indicted for first degree manslaughter.\textsuperscript{13} At trial, the jury found him guilty of manslaughter in the second degree, but recommended mercy, since the defendant was the sole source of income for his family and was found to be of “good moral character.”\textsuperscript{14} The judge, although staying execution, sentenced Repouille to between five and ten years in prison. In determining whether Repouille’s conduct conformed to generally-accepted moral conventions, the Court of Appeals noted its difficulty in reviewing the case:

\textquote[We all know that there are great numbers of people of the most unimpeachable virtue, who think it morally justifiable to put an end to life so inexorably destined to be a burden to others, and—so far as any possible interest of its own is concerned—condemned to a brutish existence, lower indeed than all but the lowest forms of sentient life . . . [T]he jury which tried Repouille did not feel any moral repulsion at his crime. Although it was inescapably murder in the first degree, not only did they [the jury] bring in a verdict that was flatly in the face of the facts and utterly absurd—for manslaughter in the second degree presupposes that the killing has not been deliberate—but they coupled even that with a recommendation which showed that in substance they wished to exculpate the offender. Moreover, it is also plain, from the sentence which he imposed, that the judge could not have seriously disagreed with their recommendation.\textsuperscript{15}]

Although motive is not a defense to a murder charge in any American jurisdiction, the perpetrator of a mercy killing usually is not punished.\textsuperscript{16} Modern cases suggest a sympathetic judicial attitude if the accused was motivated by mercy for his victim, despite the legal irrelevancy of motive. One such case involved Otto Werner, a sixty-nine year old resident of Chicago.\textsuperscript{17} Werner was charged with murder for suffocating his crippled and bedridden wife upon learning that they were being sent to a nursing

\textsuperscript{10} Id. at 198, 178 N.W. at 693.
\textsuperscript{11} 165 F.2d 152 (2d Cir. 1947).
\textsuperscript{12} Id.
\textsuperscript{13} Id. at 153.
\textsuperscript{14} Id.
\textsuperscript{15} Id.
\textsuperscript{16} \textit{See Comment, The Right To Die, 10 CAL. W.L. REV. 613, 614-15 (1974).}
home. At trial, he pleaded guilty to voluntary manslaughter and the plea was accepted. Upon receiving testimony of the defendant's loving and devoted care for his wife, the judge suggested that the defendant withdraw his plea of guilty and enter a plea of not guilty. The court then acquitted him.  

This case vividly demonstrates that although motive has never been recognized as a defense at common law, it has proven relevant through the actions of judges and juries, and has thus become a de facto mitigating circumstance. Since motive is a relevant factor in euthanasia cases, difficulties arise when the pretention is made that it is not a consideration. To solve this dilemma, it has been suggested that American law expand the role of motive in the definition of homicide. In Europe, a dramatic shift has occurred in the criminal law, in that the focus rests upon the actor, rather than the crime committed. For example, in both Switzerland and Germany, statutory law specifically recognized the motivation of the defendant in arriving at the grading of the offense and the ensuing sentence. Similarly, the German Penal Code requires that, unless "base motives" compel the commission of the homicide, a murder charge cannot be sustained. The Swiss Penal Code expressly places an obligation upon the judge to mitigate punishment when "honorable motives" induced the homicidal act.

These countries have deemphasized the traditional concepts of premeditation and deliberation, and have scrutinized the motive of the murder as a substantive element in the classification of homicide. Mitigated charges and punishment are justified on the belief that the reprehensiveness of the act is reduced when the actor is motivated by compassion and when the decedent has consented to his death. The problem of motive in the area of euthanasia is also highlighted when the role of rehabilitation, the acknowledged primary object of punishment in the United States, is evaluated. If a person has been motivated by mercy and compassion to relieve a patient of a painful existence, at the patient's own request, the likelihood of any future killing is almost nonexistent.

It is suggested that any progression from the criminality of euthanasia to its legalization should employ an examination of motive as an intermediate step, whereby motive could be afforded greater recognition as an

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18 Williams, supra note 17, at 186 n.15.
22 Id. at 363.
23 Id. at 363 n.49.
24 Id. at 363-67.
element of a homicide case. The creation of such an exception would not be unique in American criminal law. In New York State, for example, if a defendant commits a murder "under the influence of extreme emotional disturbance," the offense is reduced to first-degree manslaughter.6 The same is true in California, where it is labeled the defense of "diminished capacity."26 In both jurisdictions, while the objective act is unlawful homicide, special circumstances peculiar to the actor are recognized. The confusion created by failures to indict, acquittals, suspended sentences, and reprieves could be avoided if motive were delineated as an element of the crime.

II. THE DEFINITION OF EUTHANASIA

One of the most difficult problems attendant to many euthanasia discussions is the equivocations of authors in formulating a definition. There is "active" and "passive" euthanasia, "voluntary" and "involuntary" euthanasia, as well as several combinations of these terms. It will, perhaps, lessen the confusion if we discuss these concepts at the outset of this study.

The broadest categorization of this term distinguishes active and passive euthanasia. Active euthanasia connotes any treatment, such as a drug, which will result in the death of a terminally ill person. Active euthanasia usually refers only to those patients who first request its administration.27

Passive euthanasia is the withdrawal of life-sustaining mechanisms and treatments, such as a respirator or blood transfusion, so that a terminally ill patient may pass away quickly. Some advocates of passive euthanasia even maintain that life-sustaining treatment should be withdrawn when a dying patient is physically unable to give consent. Such consent, they argue, can be given by the next of kin or, in certain circumstances, the attending physicians, as in the Quinlan case.28

Irrespective of the validity of this nomenclature, euthanasia consti-

   Once facts are adduced which would constitute a basis for finding that defendant had both diminished capacity due to mental defect, mental illness, or intoxication, and also unconsciousness or lack of the intent to kill, the trial court...[must] supplement the statutory definition of involuntary manslaughter. It must also instruct that if, due to diminished capacity the defendant had neither malice nor intent to kill, the offense could be no greater than voluntary manslaughter.
Id. at 391, 461 P.2d at 392, 82 Cal. Rptr. at 386.
tutes the taking of a human life. One distinction which should be made, however, is between euthanasia and "allowing one to die." Joseph Fletcher, the noted theologian, proposed that the relevant criteria should be "whether on all the facts we should be inclined to speak of the activity as one that causes harm or one that merely permits harm to occur." Perhaps the best formulation of the question is that of Paul Ramsey, who rejected Dr. Fletcher's justification for inducing death, equating it "with permitting death to occur." Such confusion cannot be justified on moral grounds:

[D]oing something and omitting something in order to do something else are different sorts of acts. To do or not to do something may, then, be subject to different moral evaluations. One may be wrong and the other may be right, even if these decisions and actions are followed by the same end result, namely, the death of a patient.

What Fletcher has gained by an improper characterization of actions that allow a patient to die while caring for him—by calling them indirect voluntary euthanasia—is that, without abandoning the case he and many other moralists have made for only caring for the dying, he can more readily succeed in apparently reducing the warrants for omitting medical interventions to the moral equivalent of the alleged warrants for acts of direct euthanasia.

But to respond in this way would exhibit a considerable misunderstanding of the positive quality and proper purpose intended in only caring for the dying. . . . These actions are fulfillments of the categorical imperative: Never abandon care! . . . [T]hey effectuate or hasten the coming of no end at all. Upon ceasing to try to rescue the perishing, one then is free to care for the dying.

Ramsey insists that the criterion must always be care for the dying. We must first establish the "moral limits surrounding efforts to save life" so that medical treatment will cease when appropriate, and caring for the dying will begin. One focus must center on the life, not the death, of the patient. Thus, Ramsey has adopted a middle view, adopting neither the position that there is never a reason to cease using life-sustaining medical procedures, nor one that advocates the active killing of terminal patients. Rather, he prefers to leave the determination of when cure has become impossible, and when the process of dying has commenced, to the physician and patient together. His analysis, it is submitted, respects the subjective and objective meanings of the total situation.

Ramsey's analysis appears to offer the best hope for resolving a con-

* Id. at 144-57.
** Id. at 134.
fusing semantic problem. It does not, however, solve the problems of the reality of euthanasia, which can be viewed as a continuum of situations requiring implementation of the patient’s right to be the decisionmaker. At one end is the nonterminal patient, confronted with risks and alternatives in selecting treatment. Next, the terminal patient must decide whether to submit to life-sustaining treatment. Further along is the terminal patient who may request the discontinuance of the life-sustaining treatment. Finally, there is the terminal patient requesting that his life be shortened by the rendition of a death producing agent. All but the last situation is dealt with in Ramsey’s analysis.

III. THE RIGHT TO DIE

Is there a constitutional right to die? In a certain sense, there appears to be at least a limited right. This right arises when a deeply-held religious or conscientious motive is in issue for a competent adult, and there is no compelling state interest which insists upon the preservation of life. Since this involves the free exercise clause of the first amendment, we are not certain whether, constitutionally, such a right exists for any citizen who does not invoke the clause. It may be that, as Justice White expressed in his dissent in *Welsh v. United States*, the First Amendment itself contains a religious classification, a classification which need not be expanded to include nonreligious believers under the rubric of neutrality. If this were the case, the right should be restricted to those who object on strictly religious grounds. As will be seen, however, this right has been extended to all competent adults no longer wishing to continue life-saving treatment. Its justification, therefore, may exist under the rubric of privacy and self-determination.

Both *Sherbert v. Verner* and *Yoder v. Wisconsin* marked a major implementation of the free exercise clause. In *Sherbert*, Justice Brennan summarized the limits of state intrusion: “It is basic that no showing merely of a rational relationship to some colorable state interest would suffice; in this highly sensitive constitutional area, only the gravest abuses, endangering paramount interests, give occasion for permissible limitation.” Even if a compelling state interest is shown, the state must “demonstrate that no alternative forms of regulation would combat such...
abuses without infringing First Amendment rights." In Yoder, for example, the Court found unconstitutional a compulsory education statute as applied to the Amish, noting the absence of any state interest "of sufficient magnitude to override the interest claiming protection under the Free Exercise Clause." Yoder may be viewed as a substantial expansion of the area in which free exercise claims can viably be asserted. The test consists of an ad hoc balancing, since in each case a court must determine if a particular interest is substantial, if a person's rights are indeed religious, and if religious, whether they have been seriously abridged. Sherbert and Yoder therefore presented these criteria: if the individual demonstrates that his actions are sincerely religious and have been seriously interfered with as a result of a state regulation, the state must demonstrate that it was a compelling interest in the regulation which could not be promoted by a less restrictive means. In the absence of such a compelling interest, the state must allow the free exercise of religious activity.

"Right to die" cases may be approached in light of the free exercise clause. The cases themselves are a mixed assortment. Indeed, there are few reported instances dealing with the termination of medical treatment at a patient's request in order to permit passive euthanasia. In In re President & Directors of Georgetown College, the District of Columbia Circuit authorized a hospital to administer blood transfusions necessary to save the life of a Jehovah's Witness who was the mother of a seven month old child. The court found that the patient was "in extremis and hardly compos mentis at the time in question; she was as little able competently to decide for herself as any child would be." Therefore, the state had the "responsibility of guardianship . . . at least to the extent of authorizing treatment to save her life." Because she was the mother of a seven month old child, "[t]he state, as parens patriae, . . . would not allow . . . a parent to abandon a child . . . ." These reasons resulted in a finding of a compelling state interest. The question here—as in similar cases—is whether the interest claimed by the state properly is the subject of legislative or judicial consideration. If the state has the power to protect citizens against themselves, a myriad of intrusions will be upheld by the courts, even if free exercise rights are raised. In this case, the court found three state interests of sufficient gravity to overcome the patient's

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88 Id. at 407.
89 406 U.S. at 214.
90 Id.
41 See Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980).
43 Id. at 1008.
44 Id.
45 Id. at 1009-10.
free exercise argument: the patient was not *compos mentis*, the presence of a minor child, and the protection of the hospital and medical personnel from potential civil and criminal liability.\(^6\)

Upon close examination, the reasons enunciated here appear questionable. The patient had clearly and competently invoked her free exercise claim while lucid. Moreover, there was little likelihood of her child becoming a ward of the state since her husband, who had acquiesced in her decision, was capable of continuing his parental responsibility. Finally, both she and her husband had signed an unambiguous statement releasing the hospital, its personnel and physicians from all civil liability.\(^7\) While criminal liability arguably was possible, the circumstances of *Georgetown* clearly minimized the likelihood of such a prosecution.

This case exemplifies the courts' theoretical awareness of the fundamental nature of free exercise rights and their recognition that a substantial free exercise claim should only be denied if the state can demonstrate a compelling purpose for such denial. Nonetheless, the courts have consistently found such compelling purposes, no matter how viable the free exercise argument. The dissent of Justice Burger in *Georgetown* clearly describes this problem:

The affirmative enforcement of a right growing out of possible moral duty of the hospital toward the patient does not seem to meet the standards of justiciability especially when the only remedy is judicial compulsion touching the sensitive area of conscience and religious belief.\(^8\)

One exception to this trend was *In re Osborne*,\(^9\) wherein the court denied a request for the appointment of a guardian to consent to the administration of blood transfusions to a man who was a Jehovah's Witness. Although the patient was the father of two minor children, the court reasoned that in the event of his death, because of the close family relationship which existed, "the children would be well cared for, and . . . the family business would continue to supply material needs."\(^10\) The court also determined that the patient was lucid and capable of making a rational choice.\(^11\) As in *Georgetown*, the patient had executed a statement refusing to submit to the transfusion and releasing the hospital from liability.\(^12\) In affirming the decision of the lower court, the Court of Appeals concluded:

\(^{48}\) Id. at 1008-10.
\(^{47}\) Id. at 1009.
\(^{46}\) Id. at 1016 (Burger, J., dissenting).
\(^{44}\) Id. at 374.
\(^{43}\) Id.
\(^{42}\) Id. at 373.
In reaching her decision, Judge Bacon necessarily resolved the two critical questions presented—(1) has the patient validly and knowingly chosen this course for his life, and (2) is there compelling state interest which justifies overriding that decision? Based on this unique record, we have been unable to conclude that judicial intervention respecting the wishes and religious beliefs of the patient was warranted under our law.\textsuperscript{83}

Similarly, in \textit{In re Estate of Brooks},\textsuperscript{84} the Illinois Supreme Court held that the state could not force a Jehovah's Witness, who was mentally competent, without minor children, and willing to execute a release, to submit to a blood transfusion.\textsuperscript{85} The court premised its decision on the constitutional “right to be let alone,” thus grounding its decision on a form of the right to privacy:

Even though we may consider appellant's beliefs unwise, foolish or ridiculous, in the absence of an overriding danger to society we may not permit interference therewith in the form of a conservatorship established in the waning hours of her life for the sole purpose of compelling her to accept medical treatment forbidden by her religious principles, and previously refused by her with full knowledge of the probable consequences. In the final analysis, what has happened here involves a judicial attempt to decide what course of action is best for a particular individual, notwithstanding that individual's contrary views based upon religious convictions. Such actions cannot be constitutionally countenanced.\textsuperscript{86}

This decision, along with that of \textit{Palm Springs General Hospital, Inc. v. Martinez},\textsuperscript{87} presents a direct challenge to the validity of the compelling state interest in this area. Both decisions, involving elderly persons near death who refused ordinary treatment, declared that the sanctity of life is not seriously endangered when dying patients choose a peaceful death. The decision in \textit{Martinez} is especially noteworthy, since no free exercise argument was made.\textsuperscript{88} These holdings, it is suggested, indicate the existence of judicial support for the rationale that the “compelling state interest” test should be used to support a limited right to die, at least when a free exercise claim is made. At the same time, in light of the right to privacy, the court’s invasion of an individual’s freedom to make personal decisions, is disturbing. The essence of privacy is the individual’s ability to determine his or her destiny with little or no interference from others, including the state. Absent a clear and serious state interest, therefore,

\begin{itemize}
\item \textsuperscript{83} \textit{Id.} at 375.
\item \textsuperscript{84} 32 Ill. 2d 361, 205 N.E.2d 435 (1965).
\item \textsuperscript{85} \textit{Id.} at 372, 205 N.E.2d at 442.
\item \textsuperscript{86} \textit{Id.} at 373-74, 205 N.E.2d at 442-43.
\item \textsuperscript{87} No. 71-12687 (Cir. Ct. Dade County, Fla., July 2, 1971). \textit{See also} \textit{Byrn, Compulsory Life-saving Treatment for the Competent Adult}, 44 \textit{Fordham L. Rev.} 1, 13-14 (1975).
\item \textsuperscript{88} See \textit{Byrn, supra} note 57, at 2-4.
\end{itemize}
courts should not interfere. Such an interest, it is submitted, will only be present when there is a grave threat to the public welfare. This type of interest does not impact on an individual's decision to submit voluntarily to passive euthanasia, whether due to religious or purely personal motives.

IV. THE RIGHT TO PRIVACY

Perhaps the most decisive argument supporting voluntary euthanasia is the constitutional right to privacy. This right first received constitutional protection in *Griswold v. Connecticut,* wherein Justice Douglas expounded the concept of zones of privacy:

The foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance . . . . Various guarantees create zones of privacy. The right of association contained in the penumbra of the First Amendment is one . . . . The Fourth Amendment explicitly affirms the "right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures." The Fifth Amendment in its Self-Incrimination Clause enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment provides: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."61

If a limited right to die exists within this zone of privacy, when if ever, may a state seek to restrict such a right? In *Griswold* the Supreme Court has suggested an answer:

In a long series of cases this Court has held that where fundamental personal liberties are involved, they may not be abridged by the States simply on a showing that a regulatory statute has some rational relationship to the effectuation of a proper state purpose. "Where there is a significant encroachment upon personal liberty, the State may prevail only upon showing a subordinating interest which is compelling."62

Whether euthanasia is constitutionally permissible hinges on whether a right to reject the continuation of life exists within the "penumbra" of privacy. The essence of the right to privacy lies in the unique destiny of

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60 Thus, in the "snake handling cases," the danger to the general public through the handling of poisonous snakes for the purpose of testing one's religious faith, was sufficiently strong to override even a free exercise claim. *Cf. State v. Massey,* 229 N.C. 734, 51 S.E.2d 179, *appeal dismissed,* 336 U.S. 942 (1949); *Harden v. State,* 188 Tenn. 17, 216 S.W.2d 708 (1948); *Lawson v. Commonwealth,* 291 Ky. 437, 164 S.W.2d 972 (1942).
61 *Id.* at 484.
62 *Id.* at 497.
each human being, which may be dictated neither by law nor state. The reason is evident—to do so would destroy freedom at its very core, since freedom, if it means anything at all, is not merely a freedom from restraint and coercion, but is also the ability to choose a destiny, and to have that decision respected by others, including the state. In a sense, that is why the state exists—to safeguard each individual's freedom of choice.

This right to be left alone had been clearly recognized in the context of the fourth amendment. "The overriding function of the Fourth Amendment is to protect personal privacy and dignity against unwarranted intrusion by the State." Personal integrity is a cherished value in our society and human dignity and privacy are fundamental human interests. Justice Brandeis, dissenting in Olmstead v. United States, summarized the policy underlying the guarantees of privacy:

The protection guaranteed by the [Fourth and Fifth] Amendments is much broader in scope. The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness . . . . They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred . . . the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.

This approach was expanded in recent opinions on abortion, where the Supreme Court included in the guarantee of personal privacy those "personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty.'" This protection was deemed broad enough to include a woman's right to terminate a pregnancy. The reasoning of the Court is almost entirely negative; it is premised on the right to be left alone. This rationale, however, does not explain the right to privacy. Whether this right allows the absolute determination of an individual's destiny is unclear. Can a patient be forced to undergo a painful operation for cancer when the outcome is uncertain? Must an individual remain on a respirator when he has previously expressed a desire to die? The validity of a competent decision by an adult who suffers from an incurable disease or pathology, and whose life is sustained by mechanized, chemi-

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63 Schmerber v. California, 384 U.S. 757, 767 (1966). The Supreme Court decided that obtaining a blood sample for a blood-alcohol test did not violate petitioner's due process rights. Id. at 771.
64 277 U.S. 438 (1928). The majority held that evidence obtained through wire-tapping was admissible to prove that the defendant was guilty of violating the National Prohibition Act. Id. at 466.
65 Id. at 478 (Brandeis, J., dissenting).
66 410 U.S. at 152.
67 Id. at 154.
cal, or other such artificial means, is in issue. It is imperative that we determine whether the right to privacy encompasses passive euthanasia. If it does, the objective standards which may be applied when the patient is comatose must also be analyzed.

The rationale of *Roe v. Wade* suggests the existence of such a right. The Court relied on the notion of “meaningful human life,” rather than “potential” life, “because the fetus then presumably has the capability of meaningful life outside the mother’s womb.” The argument for euthanasia is evident—a terminal patient who has only excruciating pain or unconscious life to look forward to may no longer have the capacity for a “meaningful life.” He may therefore choose to “be left alone,” much like the woman who may decide whether or not to abort. If the right to privacy allows a doctor to kill potential human life at the request of the patient, *a fortiori*, the same right of privacy should exist when it is determined that the patient is no longer capable of “meaningful life.”

Additionally, as expressed by the New Jersey Supreme Court in *In re Quinlan*, the express desire of the patient may not be imperative; this right may be exercised by others, in the name of privacy: “we have concluded that Karen’s right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.” In other words, the right of privacy is so fundamental that others, who had been intimately involved with the patient, should be able to exercise it in circumstances when the patient is unable to do so.

*Griswold* did not define the scope of the right of privacy, but rather left its boundaries to be determined on a case-by-case basis. The *Roe* decision does offer support for a limited right to die, in the name of being left alone. Like *Roe*, the decision to die is highly private and harms, if anyone, only the individual making the decision. In a sense, the “right to die” is more personal than the decision to abort since no potentially independent life is destroyed. Indeed, such a dying patient has even less prospect for a “meaningful” life than a fetus, since the fetus would probably develop into a mature, meaningful human life. The right to privacy should therefore encompass this right to be left alone, including the refusal of procedures which will only prolong dying.

A Pennsylvania lower court has recognized the relation between privacy and the right to refuse medical care. In a case involving the refusal of a chronic undifferentiated schizophrenic to submit to cancer therapy, the court declared:

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70 70 N.J. at 41, 355 A.2d at 664.
In our opinion the constitutional right of privacy [citing Roe v. Wade, 410 U.S. 113 (1973)] includes the right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life and which, to a third person at least, appear to be in his best interests; in short, that the right of privacy includes a right to die with which the state should not interfere where there are no minor or unborn children and no clear and present danger to public health, welfare or morals. If the person was competent while being presented with the decision and in making the decision which she did, the Court should not interfere even though her decision might be considered unwise, foolish or ridiculous.71

Similarly, the New Jersey Supreme Court, in permitting an appointed guardian to decide whether to terminate Karen Quinlan's life-preserving medical care, based its decision on the right to privacy. The Quinlan Court expressly stated that the right of privacy, as developed in Roe, could justify a patient's decision to refuse unwanted medical treatment, since "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."72 Quinlan is of special importance since the decision could not be made by the patient. The analysis of the right to privacy under these circumstances is different and difficult, since the individual involved was comatose and had never expressed an opinion with respect to euthanasia. To overcome this difficulty, the Quinlan Court radically extended the right of privacy which may be asserted by a guardian. "The only practical way to prevent the destruction of the right is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances."778 Thus, the guardian, with the concurrence of the family, physicians and the hospital's "ethics committee," was permitted to authorize termination of care even when there was no direct evidence concerning Karen's wishes.74 The New Jersey Court thereby surpasses Roe in finding such an extension to the right to privacy. This is a valid development of case law and the court's holding appears well-reasoned. When there is no prior expression to terminate care, termination becomes difficult to justify under the rubric of privacy. The rationale for allowing a guardian to assert this right for a patient who has not expressed such a desire lacks a precise legal foundation. Equity, however, might provide a solution if some objective standard can be articulated.

In the absence of any legislative directive in this area, the courts

72 70 N.J. at 41, 355 A.2d at 664.
73 Id.
74 Id.
must rely on their equity powers, while avoiding arbitrary decisions premised upon subjective standards. If the patient is not capable of expressing an intent there should be a presumption in favor of life. The fundamental autonomy of the individual demands this, and triggers a presumption that life should not be terminated if no prior decision had been made by the patient. The right to privacy is, if anything, two-edged.

Moreover, it should be recognized that the problems of euthanasia and abortion involve more than a simple balancing of governmental interests and individual rights. Basic interests, as well as the patient’s own interests, may conflict. It should be recognized, therefore, that although a court may not be the ideal forum in which to resolve these essentially moral questions, no preferable alternative is apparent.

In a recent significant case, *Eichner v. Dillon*, the appellate division of the New York Supreme Court restricted the termination of extraordinary life supporting treatments to the case where the patient is “terminally ill,” in a vegetative coma characterized as “permanent,” “chronic” or “irreversible” with an extremely remote possibility of recovery. Emphasizing this “rigid standard,” the court stressed that “[t]he State’s interest in protecting the sanctity of life will tolerate no less stringent medical standard than this.” The court also explained its rationale for approving the removal of supporting apparatus from the chronically vegetative patient:

As a matter of established fact, such a patient has no health and, in the true sense, no life, for the State to protect. Indeed, with *Roe* in mind, it is appropriate to note that the State’s interest in preservation of the life of the fetus would appear greater than any possible interest the State may have in maintaining the continued life of a terminally ill comatose patient... [whose] claim to personhood is certainly no greater than that of the fetus.

Merely through the force of its own decree, therefore, this court has declared that a chronically “vegetative” patient is, in fact, dead. It has further ruled that such a person is no more a human being than a fetus. The potential abuses implicit in such language—in an opinion designed to “affirm the dignity and worth of human life”—are staggering.

Justice Mollen recognized that the task of implementing the unconscious patient’s right to refuse treatment is facilitated if he has written a “living will” or has clearly expressed his desires before the onset of incompetency. Mollen conceded, however, that “[t]his will occur only in a

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76 73 App. Div. 2d at 468, 426 N.Y.S.2d at 545.
77 Id.
78 Id. at 465-66, 426 N.Y.S.2d at 543.
minority of cases," and rejected any requirement of the patient's explicit testimony. The court thereby adopted the *Saikewicz* "substituted," or proxy judgment, rule.\(^8\)

The recurring question in these cases is: who shall make the decision to terminate treatment? The *Eichner* court spurned the *Quinlan* standard, which had suggested that these are decisions to be made not by courts, but by families and physicians with the approval of an ethics committee.\(^9\) Rather, it adopted *Saikewicz*'s ruling that these decisions "must reside with the judicial process and the judicial process alone."\(^9\) The court argued that a judicial presence is necessary to properly balance such factors as the patient's wishes, the views of the family and the concern for society,\(^9\) and concluded that "the societal interests to be safeguarded are so great that the courts have no choice but to intervene and examine each case on an individual patient to patient basis."\(^9\)

The court then enunciated the procedure to be followed when ascertaining whether life-sustaining measures should be withdrawn from a terminally-ill patient who is unable to consent to such withdrawal: (1) a physician must certify that the patient is terminally ill and in an irreversible, permanent vegetative coma, and that prospects for recovery of cognitive brain functions are extremely remote; (2) the case is then presented to a hospital committee of at least three physicians, for confirmation of diagnosis; (3) if the medical judgment is thereby confirmed, judicial proceedings must be instituted for permission to withdraw life-sustaining measures; (4) the attorney general and district attorney must be notified, and they may select additional physicians to examine the patient; and (5) a guardian ad litem must be appointed to protect the patient's interests.\(^9\)

Under this procedure, a minimum of four to six physicians, five attorneys and one judge is required for permission to withdraw extraordinary life-supporting systems from a terminally ill, chronically vegetative patient. This view, however, has been rejected by two of the nation's most distinguished medical ethicists. Robert Veatch and Richard McCormick,

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\(^7\) *Id.* at 470-71, 426 N.Y.S.2d at 546.
\(^8\) *Id.* at 473, 426 N.Y.S.2d at 548. The New York Court of Appeals limited its affirmance to the fact that the patient, Brother Fox, had expressly stated prior to his illness that he would decline life sustaining treatment if he were even placed in a situation similar to that of Karen Quinlan. 52 N.Y.2d at 378, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. The Court, however, did not indicate whether the "substituted" or proxy judgment rule of the appellate division would have been applied if Brother Fox had made no express statements with respect to the termination of life sustaining treatment.

\(^9\) 73 App. Div. 2d at 475, 426 N.Y.S.2d at 549.
\(^10\) *Id.* at 475, 426 N.Y.S.2d at 550.
\(^11\) *Id.* at 475, 426 N.Y.S.2d at 550.
\(^12\) *Id.* at 476, 426 N.Y.S.2d at 550.
of Georgetown's Kennedy Institute for Bioethics, have commented that "[w]e are convinced that the appropriate decision is so clear that it need not have gone to court, and ought not to do so in similar cases." 86

It is submitted that the analysis in Eichner was correct, at least as applied to comatose patients, since the decision to terminate the treatment of a comatose individual can only be exercised vicariously. The medical prognosis evaluation test was derived from Quinlan, but the substitute judgment which must be judicially approved was drawn from Saikewicz. While the Eichner court expressly stated that judicial involvement did not betoken a distrust either of the medical prognosis or of those who made the substitute judgment, it felt that each case would, nonetheless, require court approval in this delicate area of public policy. The Eichner procedure, however, makes such cases intolerably lengthy and expensive, and needlessly prolongs the suffering of the next of kin. Moreover, nothing is truly accomplished through the introduction of this final judicial procedure, since a court is no more able to judge the medical prognosis than the original medical personnel themselves. The Quinlan procedure, therefore, is more logical, humane, and reassuring than either that of Saikewicz or Eichner.

When the patient’s desires are unknown, and left to the speculation of family and friends, it seems appropriate that the court review the choices to be made. Judicial review is unnecessary, however, when medical criteria establish that the patient is terminally ill and in an irreversible, permanent, or chronic vegetative coma from which the possibility of recovery is extremely remote. While it is within the court’s proper sphere to enunciate general guidelines, it is neither desirable nor logical for the court routinely to review medical prognoses unless there is a real choice between painful treatment, with some chance of remission, and no treatment, with a “peaceful” death.

Since the right to die is based on the right to privacy, it can only properly be asserted by the patient himself, and not vicariously. It appears that the substituted judgment criterion, therefore, may not be logically based upon the right to privacy. When this doctrine is employed to exercise a right of privacy for the comatose individual, substituted judgment is at best an educated guess, rather than a vicariously exercised right of privacy for the patient. It is unnecessary to reach the question of compelling state interest with respect to this problem, since a “right” to involuntary euthanasia, whether active or passive, does not constitutionally exist. Case law, including the penumbra doctrine of Griswold, supports nothing more than voluntary passive euthanasia.

The difficulties inherent in involuntary euthanasia are highlighted by a discussion of the treatment of handicapped newborns. A common practice has arisen whereby parents request physicians not to treat such infants, and “allow” them to die. This is not a Roe situation, since the child has been born and, presumably, enjoys all constitutional rights. Leaving the fate of such a person to the whims of parents and their doctors is, therefore, a denial of due process and equal protection. A judicial response to this aspect of involuntary euthanasia would entail the resolution of several public policy issues, such as when is the withholding of treatment morally justified or socially desirable, and who is to make the termination decision? Legal rules must focus on criteria, procedures, and decision-making processes for implementing a social policy in this area. Courts are ill-equipped to evaluate and determine these core issues of public policy. Rather, these questions must be confronted by the legislature. The continued failure to do so will result in additional judicial confusion as well as the continued absence of objective standards to be followed by parents, hospitals, and medical personnel.

In fashioning the criteria applicable to involuntary euthanasia in this context, the legislature should recognize that any substituted consent would really constitute a misnomer. There is no possibility of determining what choice these infants would make were they able to understand their present condition. We are dealing in this instance with persons who, even if provided with life-prolonging treatment, will lead diminished lives. It is crucial, therefore, to understand that any election not to treat, outside of the “poor medical prognosis” context, is actually based on a “quality of life” determination which is essentially a question of social, and hence legislative, policy. Any legislative guidelines must be clearly defined, and the circumstances made clear. It may well be that our society is not prepared to articulate such guidelines, and is therefore willing to defer these cases either to the private discretion of parents and doctors or to the

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88 An egregious example of this biased choice is the 1971 John's Hopkins case in which doctors did not operate on a Down's Syndrome baby with duodenal atresia who died fifteen days later of starvation. The parents rejected surgery because they did not want to be burdened with a child who would be retarded and incapable of full human development. The death was completely unnecessary since mongoloids can interact, be trained and lead a reasonably comfortable life. Moreover, the child was otherwise healthy and would not have required constant medical care. The case clearly shows the necessity of full due process by the courts which have been lax in enforcing the rights of these human beings and their most fundamental right, that of life. Cf. Gustason, Mongoloidism, Parental Desires, and the Right to Life, 16 Perspectives in Bio. & Med. 529, 529-33 (1973).
courts. The consequence of such legislative delegation, however, has been judicial confusion and the attendant development of misguided termination standards, both of which combine to deny due process to defective newborns.

It is evident, therefore, that the legislature should promulgate termination guidelines, since it possesses the plenary power and investigatory mechanism to enact laws and regulations for the protection of the public health and welfare. Moreover, as an elected representative of the people, the legislature embodies the public will and policy by consent of the governed. Legislatures inherently enjoy a broader view of society than do courts, which adjudicate on an individual case-by-case basis.

V. THE QUALITY OF LIFE

A principal argument in favor of all forms of euthanasia refers to the “quality of life” of handicapped newborns, the severely retarded, and the terminally ill. The argument itself presupposes a comparative worth among human beings, raising grave moral and methodological issues which render the argument vulnerable. As in Quinlan, the argument is often made that a reasonable person would conclude that an individual suffering from intense physical and mental pain might himself conclude that such a life is not worth living, and that the patient, were he alive and capable of response, might agree. It is therefore reasonable to supply consent, as the Quinlan court did, by dividing responsibility between guardian, family, doctors and an “ethics committee.” The major determination as to when a person “has died,” or no longer has a “meaningful life,” is primarily made by the doctors. Although using vague terms such as the meaning and quality of life, the Quinlan court posited an objective standard as to when it is legally permissible to withdraw life-support systems from a comatose individual: the medical prognosis of the patient’s inability to return to a cognitive and sapient existence must be reasonably certain, the permission of family, next of kin or guardian must be obtained, and the hospital ethics committee must acquiesce in the decision. The Quinlan court thereby enunciated an objective standard, which required no further judicial intervention.

The Quinlan situation is qualitatively different from the question of treatment of severely retarded infants, for whom treatment would mean survival, albeit survival in a diminished human capacity. It is here that the “quality of life” argument is strongest and most dangerous. In the case of handicapped newborns, lack of opportunities may exist precisely because of the social attitudes and failings of healthy people. While these disabled people will never attain the achievements of “normal” people, who is to say that such a life is not worth living? The response inevitably is a value judgment, and should not be made by the judiciary since the
desire of the person most affected cannot be ascertained. Life and life alone, whatever its limitations, might be of sufficient worth to him. In *Gleitman v. Cosgrove,* a case dealing with a “wrongful life” situation, the New Jersey court stated:

It is basic to the human condition to seek life and hold on to it however heavily burdened. If Jeffrey could have been asked as to whether his life should be snuffed out before his full term of gestation could run its course, our felt intuition of human nature tells us he would almost surely choose life with defects as against no life at all.\(^8\)

The quality of life argument in support of involuntary euthanasia is especially vulnerable given the problems in obtaining another’s consent and the bias of personal or culturally relative interests. The suffering of others, no matter how tragic or personal, cannot be considered more important than the life of the unconscious, the terminally ill, or the defective newborn. Any mandate requiring an individual to sacrifice his life for the benefit of society is tantamount to an acceptance of the principle that rational utility can justify any outcome.

The major weaknesses of the quality of life argument, as well as the “meaningful” life rationale in the context of the abortion cases and euthanasia, concern the issues of who should determine when life becomes “meaningful” and to what degree the “quality” of life must be impaired before it may be terminated.\(^9\) These issues seem beyond the scope of any court to determine, since a value judgment is involved, and our pluralistic society recognized that there is no consensus as to the ultimate significance and meaning of human life. Indeed, for a court to answer such questions might represent an unconstitutional abridgement of first amendment rights. The only governmental involvement which can be acceptable is a juridical or legislative imprimatur upon a medical determination of when a particular person has passed beyond the realm of recovery, so that any further medical procedures would be futile. This is not, however, a juridical determination of the “quality of life” or what constitutes a “meaningful life.”

A recent article reported that some fourteen percent of the infant deaths at the Yale University School of Medicine Special Care Nursery were related to the withholding of treatment. The parents and physicians had jointly decided that the infant’s prognosis for a meaningful life was very poor. There have been few reported cases in this area. In one in-

\(^8\) 49 N.J. 22, 227 A.2d 689 (1967).
\(^9\) Id. at 30, 227 A.2d at 693.
stance, *Maine Medical Center v. Houle*, a male infant was born without a left eye and ear, with a deformed left hand and a tracheoesophageal fistula. Without surgical repair, a minor operation, the infant would die. The parents were informed of this and directed the physician not to operate on the child and to withhold feedings and intravenous fluids. The Center petitioned the State Superior Court for a temporary restraining order, so that intravenous feedings could be maintained, pending the court’s ruling on the question of surgical intervention. The child developed seizures which were interpreted as brain damage. The court granted the restraining order and ordered the parents not to interfere with the efforts of the physicians to perform surgery, reasoning that to do so would constitute child neglect, and that “the issue is not the prospective quality of life to be preserved.” *Houle* held that a physician’s evaluation of the quality of life is beyond the scope of a physician’s expertise. Acting as *parens patriae*, it appointed a guardian to consent to surgery and enjoin the parents from interfering with any future medical treatment.

*Houle* is significant because it reduced the termination issue to one of life or death and ignored the severe mental retardation and physical deformity of the infant. The court utilized the standards which it would have applied to any other child who was not so deformed, and declared that a child is entitled to the right of life from the moment of birth. It is interesting to note that this same reasoning was used by Judge Muir in the lower court *Quinlan* decision. The court there held, *inter alia*, that Mr. Quinlan had no authority to assert constitutional rights of privacy on behalf of his daughter, observing that “the sustenance of life, is not something degrading, arbitrarily inflicted, unacceptable to contemporary society or unnecessary.” In effect, the quality of life argument was rejected by the lower court, a position with which the New Jersey Supreme Court agreed. Although the final *Quinlan* ruling predicated the authority to terminate treatment on the right to privacy, the standard enunciated for termination—medical prognosis, consent of guardian and ethics committee—does not relate to the patient’s right to privacy. Rather, it involves an objective condition. This argument, therefore, appears flawed, and

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93 Id. This is an abnormal connection between the esophagus and the trachea which results in the child’s aspirating any formula he ingests to the point where he can actually drown from it.
94 Id. at 54.
95 Id.
97 Id. at 269, 348 A.2d at 824.
98 70 N.J. at 15, 355 A.2d at 666.
should not constitute a basis for euthanasia.

THE DEBATE OVER EUTHANASIA

The principal argument in support of voluntary euthanasia, in both its passive and active forms, emphasizes the cruelty and inhumanity of allowing continued suffering in a humanly hopeless situation, especially when the patient wishes to die. Professor Williams, espousing a quality of life view, has argued:

The absolute interdiction of suicide and euthanasia involves the impossible assertion that every life, no matter what its quality or circumstances, is worth living and obligatory to be lived. This assertion of the value of mere existence, in the absence of all the activities that give meaning to life, and in face of disintegration of personality that so often follows from prolonged agony, will not stand scrutiny. On any rationally acceptable philosophy, there is no ethical value in living any sort of life; the only life that is worth living is the good life.9

The argument continues that it is cruel to require a person to experience a painful death when there is the option of an easy death. The question should be one of individual liberty. It is a cruel law which prevents one suffering from an incurable and painful disease from escaping misery by a quick death. The finality of death, however, tempers this position. Society must uphold law for the common good of all. Moreover, it is difficult to determine when a patient, already deprived of full capacity, truly wishes to die. What is ardently desired today may be rejected tomorrow.

The Christian notion of the sanctity of life is a strong argument against euthanasia. Our criminal law itself reflects this traditional value, since it fails to recognize either merciful motive or consent defenses to homicide. Justice Brennan, writing in Furman v. Georgia,100 affirmed this traditional view:

Death is a unique punishment in the United States. In a society that so strongly affirms the sanctity of life, not surprisingly the common view is that death is the ultimate sanction. This natural human feeling appears all about us. There has been no national debate about punishment, in general or by imprisonment, comparable to the debate about the punishment of death. No other punishment has been so continuously restricted . . . nor has any State yet abolished prisons, as some have abolished this punishment.101

Supreme Court support for this value appears questionable, however, in

100 408 U.S. 238 (1972).
101 Id. at 286.
light of its affirmance of capital punishment in *Gregg v. Georgia*.

Another aspect of this problem involves the contractual duty between a doctor and patient. Such a duty is not absolute, and may be terminated either by the patient or by withdrawal of the physician, with proper notice. In cases of voluntary passive euthanasia, consent by a competent patient to his physician's termination of medical treatment appears to be tantamount to dismissal of the doctor, and as such terminates any further legal obligation on the part of the physician. The doctor, therefore, should not be subjected to criminal liability for failure to administer additional medical treatment.

One view adopts the position that life-sustaining technology in a modern hospital or nursing home prolongs life, which itself is accompanied by indignity, loss of control, and incessant pain. In such situations, permitting death with dignity is perceived as the most humane approach. This reasoning is overly broad, however, since no two patients suffer the same agonies. Thus, termination decisions must be founded upon case-by-case analyses.

The relevance of our society's often casual treatment of human life must be evaluated in light of whether we will accept euthanasia, particularly involuntary and voluntary active euthanasia. A callous disregard for the sanctity of life will only foster an erosion of respect for life. Voluntary passive euthanasia should be distinguished, since no direct action is taken in the furtherance of death, the obligation to treat ends due to the absence of meaning, and the care of the dying continues until the end. Even in its secular variety, a recognition of the sanctity of life is necessary for a humane and compassionate society. The reason is evident—most of us will someday be in one or the other above-described situations. Fairness and justice demand objective standards applicable to all. Such standards become hopelessly confused when the "quality of life" argument is added to an already difficult amalgam. As applied by the judiciary, that concept is too subjective, elastic, and arbitrary. The state's duty to protect life is also apparent as a species of state interest. By choosing euthanasia, the individual has expressly renounced the right to life. The state can assert an interest in protecting that right, and override the individual's decision to die, only when there is a compelling state interest to do so. As the state's interest grows, therefore, the individual's right to die diminishes. Conversely, as recognized by the *Quinlan* court, when the condition of the individual becomes serious, the interest of the state diminishes. Addi-

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104 *Id.* at 314, 64 P.2d at 211-12.

105 See *In re Quinlan*, 70 N.J. at 41, 355 A.2d at 664.
tionally, it should be noted that the state's interest in human life is strong when the question is one of involuntary or voluntary active euthanasia, but almost nonexistent when voluntary passive euthanasia is involved.

This aspect of state interest is highlighted by an equal protection argument. Failure to prosecute the perpetrators of involuntary active euthanasia as murderers may constitute a denial of the victims' rights of due process and equal protection of the law. At the same time, by convicting them of murder, the state may be exacting cruel and unusual punishment. These problems do not arise if euthanasia remains voluntary. In such cases as *Quinlan*, however, there is a patent denial of equal protection, since consent is either absent or deemed implicit. By failing to deal with those practicing euthanasia as murderers, the terminally ill are left without adequate legal safeguards of their right to life, although state homicide laws continue to protect others. Such a classification is inherently suspect, since it categorizes individuals on the basis of their physical condition. This approach has received little support, in light of the substantial segment of our population who seem to think that such homicide is not tantamount to murder. This sentiment, however, cannot constitute a justification for depriving individuals of constitutionally protected rights.

The scope of these due process and equal protection arguments may be too broad, since they fail to distinguish the various categories of patients. The equal protection clause does not require that similarly situated persons be treated identically, since they are not an inherently suspect class. Case law has already distinguished various types of dying persons. The existing cases have tended to protect handicapped newborns in need of treatment, although the retarded have not fared as well because their problems have been considered in light of a quality of life argument. Voluntary active euthanasia remains forbidden to the extent that aiders and abettors of suicide, even with the consent of their victims, are still regarded as in violation of the criminal law. Finally, it is safe to say that after *Quinlan* and *Eichner*, the concept and reality of both voluntary and involuntary passive euthanasia have been accepted in case law. *Quinlan* enunciated the procedure to be followed to ensure no civil or criminal liability: a hopeless medical prognosis, and agreement by physician, family or guardian, and hospital ethics committee.

There remain areas in which due process and equal protection argu-

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108 A changing public attitude concerning euthanasia is demonstrated by a 1970 Gallup Poll which showed that fifty-three percent of Americans sampled favored a law which would allow a doctor painlessly to end the life of an incurably diseased patient if the family so requested. The poll also showed that the higher a person's education the more likely he was to support "positive" euthanasia. Chicago Daily News, Jan. 19, 1974, at 5, col. 3.
ments will continue to be viable, although this will depend on how the courts accept or handle the vague standard of the "quality of life" argument, particularly as it is applied to the senile and the severely retarded.

These issues, however, can only be regarded as in a state of flux. Many questions of public policy remain to be articulated, since our society must some day grapple with the unpleasant questions of which categories of these persons it does not want to treat, and for what reasons. These policy issues have been avoided thus far in deference to fanciful judicial discussion concerning "substituted judgment."

VII. Handicapped Newborns

Perhaps the most perplexing involuntary euthanasia cases are those in which severely disabled infants are allowed to die in accordance with the common agreement of the parents and physician. Since a newborn cannot consent to necessary treatment, the primary question is who should decide whether treatment should be provided.

For an adult, informed and uncoerced consent is a necessary part of any form of medical treatment. We deal here with those who are endemically incapable of such consent. What, then, should be the termination criteria? Courts have approached this problem in a variety of ways. One line of inquiry, adopted by the Quinlan court, seeks to ascertain what the handicapped newborn would prefer. This is a flawed question, however, since it injects our own values onto the child, who has no basis for the fears and horrors we might have for ourselves in a similar state. We project our values onto the child by this quality of life argument, which presupposes not only a higher level of health, consciousness, and awareness, but also a degeneration from that state. By definition, this condition is absent from the defective newborn, who might well be happy and satisfied to live out his limited human potential, having never realized what is absent. We must not confuse our suffering with that of the child who has never known any other existence and who may be perfectly content to live with his deformities. Indeed, a surprising number of these children are capable of giving and receiving love and taking care of themselves. In protected or sheltered environments, many of them can lead productive lives.

Correlations exist between the degree of parental acceptance of

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107 For a comprehensive survey of this question, see Robertson, Involuntary Euthanasia of Defective Newborns: A Legal Analysis, 27 STAN. L. REV. 213 (1975).
handicapped children and religion, social class, and the presence of supportive friends and relatives. There is no certain mandate that a diminished future must trouble a person who has known no other type of life. Why, then, should such a person be killed "for their own good" or, similarly, not treated as other "normal" children and thus "allowed to die?" As a society, we must be skeptical of a strong group willing to condone the killing of a weaker group "for their own good."

The easier cases to decide in this area involve those persons whose medical prognosis is without hope, and who would die in a very short time regardless of any efforts. As will be seen, once such a diagnosis has been made in good faith, support systems may legally and morally be discontinued, since such procedures no longer have meaning or significance. One is obligated neither to do the futile nor continue the useless. This was the basic conclusion of the Quinlan court as it announced the procedure to be followed in such cases, without further judicial intervention.

More difficult cases are presented by the mentally or physically handicapped persons who certainly will live diminished lives, but from whom accepted and comparatively simple procedures are withheld so that they are "allowed to die." Although there are many arguments for such non-treatment, the present discussion will be limited to the contention that such children should be allowed to die "in their own best interests." This situation is the most difficult, of course, since there can be no input from the child. The only available method is that of substituted judgment, with all its pitfalls of value substitution. The problem confronted is both moral and legal. The moral question addresses which category of patients our society does not wish to treat. The legal question involves the equal protection difficulties arising from the special treatment of these people.

It should be clear that neither parents nor physicians can be authorized to make such decisions for another human being. Each has a significant conflict of interest which impairs his judgment. The parents may be influenced by their desire to save their own psychological and economic lives, as well as those of their other children. In this sense, the handicapped children become a "burden." The question which must be asked,
however, is to whom? Similarly, the physician is most affected by those whose feelings are most visible and tangible—the parents. In fact, most physicians tend not to want to treat such infants, since they may be viewed as representing a failure for the physicians, who may consider such infants better off dead, even though some parents do not in fact share these views. If these studies are correct, a significant problem exists, since it demonstrates that many treating physicians believe in the "quality of life" theory.

Who, then, can be trusted with such decisions? The Quinlan case posited a protective scheme for incompetents who are in a hopeless situation. The same reasoning may be applied to newborn handicapped children. While acknowledging the parents as appropriate guardians and recognizing their right to participate in the decision to terminate treatment, the court stated that such a decision would be legally valid only if it had the approval of a hospital ethics committee. Whatever one thinks of the ideal function of such a committee, it does acknowledge the impermissibility of a physician and family making such important decisions alone. This method of decision diffusion should not be construed as an unwillingness to assume personal responsibility on the part of parents and physicians, but rather as an incipient effort to reach a societal consensus. This approach is in accordance with Professor Robertson's suggestion that society, through the legislature or courts, should recognize certain objective criteria which can justify the refusal of treatment:

As authoritative and specific criteria have eased the physicians' determination of when brain death has occurred, the risks of delegating treatment to parents, physicians, or committees can be similarly lessened if specific criteria are developed to describe defective characteristics in the familial or institutional situations in which treatment may be withheld from defective infants.

It also seems that parents should be informed of the possibility of taking handicapped infants home. Recent studies have shown that a wholesome familial experience is much more prevalent than previously suspected: "[t]hose who have lived with the handicapped seem to reject any necessary incompatibility between being handicapped and leading a worthwhile life, a conclusion that ought to be taken into account by those charged with making decisions about 'the right to life' of infants with

118 See Darling, Parents, Physicians and Spina Bifida, 7 HASTINGS CENTER REPORT 11-12 (August 1977).
119 Id. at 12.
120 70 N.J. at 54, 335 A.2d at 671.
121 Annas, In re Quinlan: Legal Comfort for Doctors, 6 HASTINGS CENTER REPORT 29, 31 (June 1976).
122 See Robertson, supra note 107, at 266.
Birth defects.\textsuperscript{123}

Studies of Protestant and Catholic mothers of retarded children showed the latter to be far more accepting of their children than the former. Zuk concluded that Catholics were more accepting "due to the explicit absolution from personal guilt offered by their religious belief," and that a mother could accept the child in a framework of "a test of her religious faith . . . a special gift of God."\textsuperscript{124} Moreover, women are much more accepting of handicapped children than men, regardless of the cultural or intellectual level.\textsuperscript{125} Cultural levels, however, are also relevant. "[T]he appearance of a defective newborn is more self-devastating than in an earlier time when a family needed more children and when children were not so regarded as expressions of the selves of parents."\textsuperscript{126}

Middle-class culture stresses the perfect and normal, and loathes the imperfect and defective. With the developing technology, such as the technique of amniocentesis, handicapped newborns are frequently looked upon as "mistakes" which could have been prevented through selective abortion, a procedure which is accepted by the vast majority of the American people.\textsuperscript{127} It is reasonable to conclude that attitudes toward handicapped newborns will become progressively more negative as the processes of prenatal diagnosis become more perfect and those who are not perfect are aborted. One can therefore expect an increase in the number of parents who will attempt to instruct physicians not to treat a seriously handicapped child. As one expert has stated: "[m]ost parents in our society if given the choice would prefer abortion of an affected fetus to a sick child who requires any but the most trivial treatment. The preference is likely to become more definite with rapidly changing attitudes to abortion at a time when the low risks of amniocentesis will become fully established and when simple abortion techniques become available."\textsuperscript{128}

Since abortion of the defective fetus is so widely accepted in our society we find it less difficult to withdraw medical care from handicapped children. Indeed, once the law recognizes the right to actively end the human life of the defective unborn, the logic of such a utilitarian ethic will be difficult, if not impossible to control with regard to handicapped newborns. Perhaps the best suggestion comes from Professor Robertson:

\textsuperscript{123} See Darling, supra note 118, at 13.
\textsuperscript{124} Zuk, supra note 112, at 145.
\textsuperscript{125} Lazar & Orpet, Attitudes of Young Gifted Boys and Girls Toward Handicapped Individuals, 38 Exceptional Children 489-90 (1972).
\textsuperscript{126} Fletcher, Attitudes Toward Defective Newborns, 2 Hastings Center Studies 21, 27 (1974).
\textsuperscript{127} Id. at 30.
\textsuperscript{128} Motulsky, Public Health and Long-Term Genetic Implications of Intra-Uterine Diagnosis and Selective Abortion, 7 Birth Defects 31 (1971).
If recognized by the courts or legislature, such criteria [to describe defective characteristics] would represent a collective social judgment, rather than idiosyncratic choices of parents and committees, as to when social costs outweigh individual benefits. To achieve legislative consensus, the criteria for death should necessarily be narrow, reaching only the extreme cases. Further protection can be obtained by a procedure that insures that the required clinical findings are accurately assessed, for example, by certification of two nonattending physicians before treatment is withheld.129

The most difficult problem is to restrict this criterion for death to the extreme cases.130 While proper legal procedures may minimize the risks to others, the real danger is the outgrowth of measures which have already been morally and legally accepted. In the final analysis, this is not a direct problem of law, but of society's attitude toward handicapped human life.

VIII. INCOMPETENT PATIENTS: THE LEGAL STANDARDS

**Euthanasia and the Right to Die**

As we have seen, it is difficult to speak of "euthanasia"—whether active or passive or voluntary or involuntary—because the term is difficult to define. An essential connotation of "euthanasia" is that people who have the option of choosing life choose death. In the words of Arthur Dyck, it is not euthanasia when a person "does not choose death but how to live while dying."131 Some have termed this "voluntary passive euthanasia," but this terminology should be avoided because of possible confusion with other uses of the term. When the dying process has become medically irreversible, the issue is not whether medical treatment should be continued, since it is useless, but how best to aid and comfort an individual while he is dying. The choice, while limited, is a choice for life, not for death, since the patient chooses to live in the best way possible. This distinction simplifies the work of the decision-maker, and leads to a two-fold procedure, involving a medical prognosis and the consent of the doctor and family.

In cases when there is no next of kin and the patient has expressed no preferences, a court hearing and appointment of a guardian is in order, since some form of consent is necessary to ensure due process. This procedure precludes the decision-maker's involvement with the arbitrary "quality of life" concept. The essential question, which only our society

129 Robertson, supra note 107, at 266.
can answer, is a moral one—is it ever wrong to choose death? In a context of the inevitability of death, the interests of the state substantially diminish and the interests of the individual grow. The privacy interest—that which determines one’s destiny in the face of death—becomes very strong and the state’s interest in preventing suicide and defending innocent life weakens. Thus, the moral and legal context dovetail.

In our present discussion, death is not directly chosen, although a medical determination is made whether any medical intervention will forestall death, provide remission, or cure. If it is determined that any medical intervention is useless, we may morally and legally omit these procedures except to the degree that they aid and comfort the patient in living well while dying. A competent individual may himself choose to forego the medical procedures which prolong his dying, and a family or guardian may do so for an incompetent patient. Death is not caused by this omission or the removal of machines, but rather by the disease itself. It is entirely misleading to call this passive euthanasia, since it is no longer possible to rescue the sick person. We must, therefore, comfort the dying. This should be the basic principle in deciding whether or not to remove life sustaining technology from the patient. Once such criteria are established, case-by-case judicial intervention would be unnecessary.

These criteria direct our attention to the objective condition of the patient, rather than the subjective wishes of family, doctors, “spiritual” leaders, or judges. While there may be some margin of error and uncertainty, this is an objective medical determination. A court may therefore enter appropriate orders in the best interests of an incompetent. Court intervention would also be necessary in instances when there is a difference of opinion between physician and family, or when the patient is mentally deficient, although not comatose, and the medical procedure would prolong life for only a short time.

Under this standard, all required treatment could be ordered and administered by the court for the terminally incompetent. This may be done because the court represents the person of the incompetent. There will be cases in which these medical interventions will help, while in others, there will be no response to intervention. In the former, treatment will be ordered since the presumption should be to favor life when the patient has no capacity to participate in the decision affecting his life and death. When it is determined that the situation is hopeless, treatment should cease and comforting should begin. At this point, all medical technology can morally and legally be removed, except as to that treatment which may be conducive to the comfort of the patient, thereby permitting

THE RIGHT TO DIE

the inexorable process of the disease to take its course. Cases will arise wherein a factual determination must be made. In such instances, courts should heed the advice of theologians, ethics committees and the like, so that a truly wise and personal decision can be made. In Superintendent of Belchertown State School v. Saikewicz the court stated:

[T]he probate judge may, at any step in these proceedings, avail himself or herself of the additional advice or knowledge of any person or group. We note here that many health care institutions have developed medical ethics committees or panels to consider many of the issues touched on here. Consideration of the findings and advice of such groups as well as the testimony of the attending physicians and other medical experts ordinarily would be of great assistance to a probate judge faced with such a difficult decision. We believe it desirable for a judge to consider such views wherever available and useful to the court.

If the starting point of the inquiry is the necessity of medical treatment, the task of the court will be reasonable and sensible.

IX. QUINLAN, SAIKEWICZ AND SPRING

The Quinlan Decision

The legal standard adopted by the Quinlan court, that of cognitive and sapient life, satisfies the objective standard of the medical indication test discussed above. The facts in Quinlan indicated that no known medical treatment would have been of any use to Karen Quinlan. The medical technology therefore only prolonged her dying and should have been discontinued on that basis alone, provided the proper consent of physician and family was present. It was not necessary for the court to discuss and approve the distinction between ordinary and extraordinary measures, which is itself a continually shifting legal standard. The case of the dying, comatose incompetent should always be carefully distinguished from other situations involving the potential termination of treatment. In these cases, if life-sustaining treatment is ordered withdrawn, there is absolutely no intent to kill, but rather the wish that life be unencumbered by useless and meaningless machines, tubes, and medications. Such a person dies through the instrumentality of the disease, not through the instrumentality of a human agent.

Karen Quinlan was a dying, incompetent patient. If the court had simply applied the standard already discussed, which in fact it finally did, the intricate and confusing distinction between ordinary and extraordinary medical interventions and the presumed and imputed exercise of the

134 Id.
right of privacy would have been unnecessary. However, the court’s discussion resulted in needless confusion. Indeed, the opinion possesses a dangerous tenor. Further, by making Karen Quinlan’s cognitive and sapient state the gravamen of its decision, the court has introduced, at least sub silentio, a quality of life legal standard which may have dangerous results when applied to other categories of human beings having low degrees of cognitive life. Indeed, the Quinlan court imputed a will to die to the comatose patient, thereby permitting the guardian to take the necessary measures to remove the life-sustaining machinery. The decision, therefore, authorized others to bring about the death of a human being based upon the tenuous assumption of an imputed desire to die. This is a dangerous legal standard, since the distinction between voluntary and involuntary euthanasia is weakened. The Quinlan decision, therefore, approaches involuntary euthanasia by allowing consent to be imputed to an unwilling and nonconsenting patient.186

These confusing and dangerous legal standards could be avoided by the application of a medical indication standard. Thus, when the patient is in a situation where further curative efforts are useless, he should be allowed to live as well and as comfortably as possible while he dies. This is a medical determination since doctors can, within certain limits, ascertain whether such a condition exists. It is also a legal determination, because protective procedures in an adversary process are employed to protect the interests of the dying incompetent. Death, which comes to all, must eventually be accepted. The words of George Annas are appropriate in this context:

The opinion should stand as a monument illustrating how far a court will go to encourage physicians to do what it wants them to do in a particular case. Its looseness of language and potential for abuse demand to be exposed and discussed. Above all, it should be limited to the facts of this case and not imposed on other patients whose rights it may destroy rather than protect.187

The Saikewicz Case

Joseph Saikewicz, a sixty-six year old man was profoundly retarded, with an IQ of below 25.188 Since his mental age was less than three years, he was institutionalized all his life. While he was able to communicate by gestures, he could not do so verbally.189 In April 1976, he was discovered

187 Annas, supra note 121, at 31.
to have acute myeloblastic monocytic leukemia, a fatal disease. The only
known treatment for the disease is chemotherapy, offering a thirty to fifty
percent remission possibility, which is limited to from three to thirteen
months. The treatment has serious side effects, including pain, discom-
fort, and in some cases, death. Physical restraints would have to be used
on Mr. Saikewicz, because he was not capable of understanding the rea-
son for the treatment. If he were to be untreated, he would live for some
weeks or months, after which he would probably die without pain. The
case presented an example of an incompetent who might be helped by a
medical procedure, and was therefore distinguishable from Quinlan.

One week after the diagnosis, the Superintendent of the Institute of
Belchertown petitioned the Massachusetts Probate Court for a guardian
to make necessary decisions for the care of Mr. Saikewicz. The court ap-
pointed a guardian ad litem. At the hearing, two physicians testified
against treatment, and the judge ordered that no treatment be given. His
order was based on findings that the factors favoring treatment, including
the possibility of an extended life expectancy and the fact that most pa-
tient’s do choose treatment, were outweighed by the factors against, such
as the patient’s age, incapability to cooperate, the side effects, and the
low probability of remission.

An immediate appeal was taken to the Supreme Judicial Court of
Massachusetts, which affirmed the ruling of the probate judge. On Sep-
tember 4, 1977, Mr. Saikewicz died of bronchial pneumonia, without ap-
parent pain. The Massachusetts Supreme Court then issued its full deci-
sion, discussing the major issues surrounding the treatment of dying,
incapable patients. Although clearer than Quinlan, it concludes with
an implicit quality of life argument for denial of treatment.

The differences between Saikewicz and Quinlan are immediately ap-
parent. The “cognitive and sapient life” of Saikewicz was the same before
and during his illness. The decision of the lower Saikewicz court consid-
ered the patient’s retardation when it discussed its own “quality of life”
argument against treatment. It appears that the very condition of Mr.
Saikewicz was used by the court as an argument against his being treated.
The decision of the probate court was, therefore, not a purely medical
decision, since the quality of life argument was utilized.

This quality of life view was adopted by the examining doctors.140 In
fact, both physicians testified that if Mr. Saikewicz were competent, they
would offer him the choice of accepting chemotherapy. All parties stipu-
lated to the fact that the vast majority of competent patients do in fact
accept chemotherapy. The court, however, used a subjective standard of

July 9, 1976) [hereinafter cited as “Appendix”].
substituted consent:

In short, the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.\textsuperscript{141}

The decision is premised on the probability that Mr. Saikewicz would refuse treatment because he would see himself as retarded, and conclude that his life was not worth living. The court thereby imposes its quality of life view upon Mr. Saikewicz. This \textit{circulus vitiosus} is compounded by the fact that a child of three years could not understand the meaning of suffering, who would have to be restrained during treatment, who would suffer the same side effects and experience the same possibility of remission, would simply \textit{not} be denied chemotherapy. If it is argued that the cases are distinguishable because the three year old child’s mental age will develop, the quality of life argument, which the court sought to deny, is conceded.\textsuperscript{142} The \textit{Saikewicz} brief aptly indicated that the fundamental reason for non-treatment was a condition for which Saikewicz is in no way responsible:

[F]ailure to provide Mr. Saikewicz with chemotherapy may be in violation of his constitutional right to treatment. Similarly, to deny Mr. Saikewicz treatment, which a majority of competent patients choose, on the grounds of the quality of life that Mr. Saikewicz would lead under chemotherapy (the quality of life being judged to be so poor on the basis of his retardation) may violate Mr. Saikewicz's right to equal protection under the law.\textsuperscript{143}

The court’s analysis of the argument for substituted consent is confronted by the impossible task of attributing to the patient that which simply cannot be discovered. Since this was not a question of a dying non-competent patient for whom no medical treatment would help, the added element in the decision must be the mental condition of Mr. Saikewicz. If his life were extended by the treatment, he would continue an impaired cognitive life. It was erroneous, therefore, for the \textit{Saikewicz} Court to analogize to the \textit{Quinlan} case, since the fact situations were radically different. In \textit{Quinlan}, the hopelessness of any curative medical procedure had to be resolved, while in \textit{Saikewicz}, the medical indication was clear both from the intrinsic and extrinsic evidence. It was the probate court’s finding that most normal patients who suffer from the same disease choose chemotherapy. This was regarded as a clear indication of how

\begin{enumerate}
\item \textsuperscript{141} 370 N.E.2d at 431.
\item \textsuperscript{142} \textit{Id.} at 432.
\item \textsuperscript{143} Appendix, \textit{supra} note 140, at 24. Nowhere does the court make reference to this argument in its opinion.
\end{enumerate}
Mr. Saikewicz would choose it if he were capable of doing so.

When the patient has not expressed an opinion on these matters, the criteria for substituted consent must be objective, and must contemplate what most people would do under the same circumstances. Any other test is simply an arbitrary stipulation which permits the decision-maker to introduce and give weight to his own weltanschaung. It is submitted, therefore, that the quality of life criteria should not have been adopted. Although the Massachusetts court held that the right of privacy can be asserted for an incompetent by an impartial court in an adversarial proceeding, it set aside the traditional standard used for a "normal" child or patient, and replaced it with subjective criteria, treating Saikewicz as if he were a competent patient who would then "reasonably" take into account the fact that he was incompetent. The court apparently turned the objective criterion for incompetence—what most people in the same condition would choose—into a subjective criterion by the miracule dictu of the impossible. The door is not open to all forms of abuse, in determining the fate of incompetents who would perhaps choose not to live if they had knowledge of their incompetence as determined by the rational and objective decisionmaker. There is every reason to believe that this legal standard will follow the logical route of its development. The Saikewicz court explained:

Individual choice is determined not by the vote of the majority but by the complexities of the singular situation viewed from the unique perspective of the person called on to make the decision. To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality.\footnote{144 370 N.E.2d at 482.}

The substitution of judgment standard was originally enunciated to guard the dignity and worth of the incompetent in the name of objectivity. The court frustrates this purpose for one reason: the mental condition of Mr. Saikewicz. Informed consent for the incompetent should receive every protection, both procedurally and substantively, so as to prevent, as much as possible, the personal prejudices and philosophy of the decisionmaker from being imposed on the incompetent in the name of dignity and personal worth.

The criterion used by the court may nonetheless be understood in an objective manner. It is true that the majority of "normal" people in the same situation as Mr. Saikewicz would choose chemotherapy. The question we have raised asks whether the court should deny what the majority of normal people in similar circumstances would choose. This is dependent, at least indirectly, upon a quality of life determination by the court.
In the case of conscious, mentally competent people, the human meaning of their choice for chemotherapy is a continuation, even for a few months, of an effectively human conscious existence whose choice was freely made. In the case of Mr. Saikewicz, however, this objective human meaning of choice is not and cannot be present. In fact, as the court recognizes, Mr. Saikewicz would not even understand the reason for the additional pain and suffering which such a procedure would entail. A continuation of this state would therefore have little human meaning. In this light, the situation presented by Saikewicz may be distinguished from that of Quinlan. It therefore cannot be said that the standard used by both courts was purely subjective. At the same time, substituted judgment remains a form of judicial fantasy which, although perhaps necessary, should remain objectively based.

The Spring Case

The Massachusetts Supreme Judicial Court recently decided a case in which it sought to clarify Saikewicz. In In re Spring, the court approved the removal of seventy-eight year old Mr. Spring from kidney dialysis. The probate court decision was in response to an application from his wife and son. A final opinion of the Massachusetts Supreme Court, issued approximately one month after Mr. Spring died, stated that "[l]ittle need be said about criminal liability: there is precious little precedent, and what there is suggests that the doctor will be protected if he acts on a good faith judgment that is not grievously unreasonable by medical standards." The most disturbing aspect of this case is the court’s broad language concerning the quality of life of nursing home patients such as Mr. Spring. The court concluded that Mr. Spring “would, if competent, choose not to receive the life-prolonging treatment,” and dismissed any reference to the quality of life standard, contending that “[t]he problem of impairment of ‘quality of life’ associated with Saikewicz’s mental retardation has no analogue in the present case.”

The facts in Spring, however, like Saikewicz, do reveal “quality of life” considerations. Mr. Spring himself had never stated any preferences regarding medical treatment should he become incompetent. Evidence was adduced that while Mr. Spring was alive, he led a vigorous, active life. The decision was necessarily based on what others—the family and court—think Mr. Spring would have wanted and was a clear example of

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146 405 N.E.2d 115 (Mass. 1980).
147 Id. at 122-23.
148 Id. at 122.
substituted judgment. The court took the view that Mr. Spring’s condition was “irreversible and incurable,” but did not acknowledge that this is true for all patients who suffer from chronic kidney failure and who are not candidates for transplantation.

Application of the court’s analysis to senile persons is even more disturbing. By reasoning that “[t]he treatment did not cause a remission of the disease or restore him even temporarily to a normal, cognitive, integrated, functioning existence, but simply kept him alive,” the court recognized a broad standard, without legal precedent: if one is not and cannot be returned to a normal, cognitive, integrated, functioning existence, but can simply be kept alive, it is not required that one be kept alive. This standard could be applied to a wide spectrum of the retarded, including all senile persons in nursing homes.

The Quinlan standard, it should be noted, was narrower. If the family, physician, and a hospital ethics committee all agreed that “there is no reasonable possibility of returning to a cognitive, sapient state,” then lifesupporting measures could be withdrawn without legal liability. This in itself is a type of “brain death” definition. It narrowly defines a category of patients who need not be treated, and thus is a safer and more precise criterion for treating such patients.

Since the Massachusetts court’s standard is overly broad, it would be preferable to adhere to the more narrow standard of the Quinlan court, which incorporated the medical prognosis test. Application of this criterion would be unencumbered by complicated judicial intervention. The notion of “substituted judgment” in a case where the patient has expressed no desire as to treatment must be recognized as a retreat to fantasy. The criteria relied on by the Quinlan court are humane, efficient, and respectful of privacy. Moreover, the standard enunciated in Saikewicz and Spring are dangerous for large segments of the retarded and senile, since the court is permitted to impose its own value judgment.

CONCLUSION

The question of whether to treat, continue to treat, or to remove curative means from a dying incompetent must be determined on a case-by-case basis. The medical profession alone can determine whether further curative methods will be of any help. The family should be listened to carefully in an effort to determine what the incompetent desired when still competent. Spiritual and religious advice should also be sought. This process need not be adversarial.

The person of the incompetent must vigorously be represented by a

100 Id. at 118.
101 Id.
guardian *ad litem* who will defend the basic right to life of the incompetent. The role of the judge is not that of a new priesthood, but calls for a determination of what is in the best interest of the incompetent. The legal standard which the court employs must be objective in nature, predicated on what most competent people elect to do under similar circumstances. There is no authority to speculate, fantasize, or impute decisions to an incompetent. Every reasonable doubt must be resolved in favor of prolonging the life of the incompetent. Judicial intervention should be restricted to instances when there is no next of kin, when there is a dispute between family members and the family physician, or when there is evidence of malevolent motives or medical negligence.

John Rawls' *A Theory of Justice* provides insight into how we should proceed in such cases. A theory of “justice as fairness” is proposed, in which what ought to be done is determined by asking what we would agree to if we did not know what role we would play in life. This minimal demand of justice will insist on a procedure that will not be unreasonably delayed, that will not distress one's family, and that—as much as the human state of fallibility allows—will safeguard the right to decide whether to struggle for yet another morning or slip gently into the night.

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