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A MORAL DILEMMA: THE ROLE OF JUDICIAL INTERVENTION IN WITHHOLDING OR WITHDRAWING NUTRITION AND HYDRATION

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There would be no moral dilemmas if moral principles worked in straight lines and never crossed each other.¹

How does a trial court or a reviewing court resolve the moral and social issues involved in withholding and withdrawing nutrition and hydration from a human being? Judges have the power to decide justiciable issues and to compel compliance with their decisions. In the absence of a legislatively expressed public policy, however, the courts lack a justiciable issue to consider and to decide the moral and social issues surrounding the withholding and withdrawing of nutrition and hydration.² When an individual, now incompetent to express an intent about withdrawing or withholding nutrition or hydration, has not previously expressed feelings on the subject, or when an individual is not terminally ill or in imminent danger of dying, the lack of a justiciable issue is apparent.

There was a time when death was recognizable. Today, however, the difficulty in defining death creates a moral dilemma. This dilemma should be resolved by society, communities, literature, philosophy, theology, and science. The inability of society to reach a

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2. Justiciable is defined as a “matter appropriate for court review.” BLACK'S LAW DICTIONARY 777 (5th ed. 1979).
moral consensus has resulted in fundamentally different and incongruous results and justifications in the reported decisions. Trial and reviewing courts have created fictions to reach inconsistent decisions at this confluence of morality and law.

There is a way to reach an appropriate result without creating a fiction to convolute the judicial system. The legislative bodies of our several states must act to express their public policy and provide a means to resolve the moral dilemma of withholding or withdrawing nutrition and hydration. The basis for judicial intervention should be founded upon an enunciated public policy of the moral efficacy for such intervention.

Judicial intervention raises a troublesome question in the absence of pronounced public policy: At what point in the continuum of life does death occur? The words of Justice Blackmun about the beginning of life are instructive when he said in *Roe v. Wade*:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.  

The court could not enunciate a moral standard founded upon an established public policy, and therefore enunciated a medical standard for which medical professionals would not be held liable. I suggest the same difficulty arises in the speculation about the end of life or participating in the decision that permits an act to occur which may directly or indirectly contribute to the end of life.

The resolution and justification for judicial intervention requires the imposition of a moral attitude peculiar to the particular judge hearing the evidence. The hearing and decision compromise the basic right of various communities within an organized society to determine a public policy or moral standard as to when life no longer exists or the quality of life is diminished. This creates a moral ambiguity. Judges resolve the moral ambiguity by creating a fiction, calling it substituted judgment, in order for the judicial system to justify its intrusion into one of the most personal, private and intimate decisions of all human existence.

The original ethical guide of medical treatment was set forth in

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the famous ancient Hippocratic Oath which "represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day." People for many generations believed a medical professional was bound to the principles espoused in the Oath. At one time all medical students subscribed to the oath prior to establishing their practice of medicine. Today, although many medical students do repeat the oath upon graduation, some do not. The Hippocratic Oath is not a part of the licensing requirement of the medical profession.

The American Medical Association (AMA) adopted Revised Principles of Medical Ethics in 1980. Like the Hippocratic Oath,
the Principles of Medical Ethics are not a part of the licensing requirement of the medical profession. In 1986 the AMA Council on Ethical and Judicial Affairs issued a statement on withholding or withdrawing life prolonging medical treatment. Neither set of principles effectively dealt with a definition of death. Inconsistencies are apparent among the Oath of Hippocrates, the 1986 statement of the AMA Council on Ethical and Judicial Affairs, and the criteria established in a report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death.

Medical professionals, in the practice of their art through research and science have developed the ability for kidney dialysis,

indicated.

VI. A physician shall in the provision of appropriate patient care, except in emergencies be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Id.

8. The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interests of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment. Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition, or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.


9. See supra note 6 for text of Oath of Hippocrates.

10. See supra note 8 for text of statement.

11. The Ad Hoc Committee established the following criteria to define brain death:

(a) a being is unresponsive to externally applied stimuli normally painful;
(b) there is an absence of spontaneous muscular movements and spontaneous respiration;
(c) there is an absence of reflexes to external stimuli; and
(d) there is a flat electro-encephalogram over a 24-hour period indicative of no brain function, cognitive function, brain stem activity or spinal cord responses.

organ transplants, mechanical organs, respirators, and ventilators to simulate breathing. The respirator or ventilator forces oxygen into the bloodstream, which circulates to force oxygen to the brain and maintains brain activity. Similarly, mechanical devices may be inserted for forced nutrition and hydration. One singularly, or in combination with others, can sustain a human being. The question is whether it is moral to mechanically sustain a human being and prolong life or deny death.

The term "medical treatment" has been given different meanings from time to time by the medical profession, as well as by decisions of various courts. The determination of what constitutes "medical treatment" has been modified by the principles of medical ethics promulgated by the American Medical Association in its Opinion 2.20.12

As the medical profession has redefined the term "medical treatment" with regard to withholding or withdrawing nutrition and hydration, some courts, lacking a prior expression by a community or society, have created a means presupposed by experience to express that new meaning in an attempt to satisfy rational analysis. The result is not consistent throughout the United States. This inconsistency is due to the lack of a singular moral concept in our pluralistic society concerning what constitutes "medical treatment". That void emphasizes that judges are unable to resolve, without resorting to legal fictions, the moral ambiguity that communities and societies are unable or unwilling to resolve. The public policy

12. Withholding or Withdrawing Life-Prolonging Medical Treatment The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. If the patient is incompetent to act in his own behalf and did not previously indicate his preferences, the family or other surrogate decision maker, in concert with the physician, must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient to die when death is imminent. However, the physician should not intentionally cause death. In deciding whether the administration of life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf the surrogate decision maker and physician should consider several factors, including: the possibility for extending life under humane and comfortable conditions; the patient's values about life and the way it should be lived; and the patient's attitudes toward sickness, suffering, medical procedures, and death.

Even if death is not imminent but a patient is beyond doubt permanently unconscious, and there are adequate safeguards to confirm the accuracy of the diagnosis, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or permanently unconscious patient, the dignity of the patient should be maintained at all times. (I,II,III,IV,V). PRINCIPLES OF MEDICAL ETHICS Op. 2.20 (Am. Med. Assoc. 1986).

Roman numerals at the end of the opinion refer to the Principles of Medical Ethics, supra note 7, which are particularly relevant to the opinion.
determination of a moral standard should be left to decision making bodies other than the judiciary. A judge, from time to time, is required to resolve justiciable issues created by ambiguities in acts of the legislature. The resolution of a moral and social ambiguity is not, however, a justiciable issue.

WHAT IS THE ROLE OF A JUDGE IN DETERMINING TO WITHHOLD OR WITHDRAW NUTRITION AND HYDRATION

The judge is but one decision maker among many. Others include the patient, the patient's family, agent, custodian, or guardian, the legislature, medical practitioner, hospital administrator, and hospital ethics committee. The United States Supreme Court has said "No right is held more sacred or is more carefully guarded by the common law than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."13

The genesis for establishing the now accepted conclusion that a competent person is the appropriate decision-maker began with Judge Benjamin Cardozo, as early as 1914, when he recognized a common law right to be let alone. In an action for damages against a doctor for a lack of consent to surgery, Judge Cardozo wrote, "Every human being of adult years and a sound mind has a right to determine what shall be done to his own body."14 Similarly, Justice Louis Brandeis said, "The makers of our constitution undertook to secure conditions favorable to the pursuit of happiness.... They conferred, as against the government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men."15

The modern basis for judicial intervention emanates from Griswold v. Connecticut16 in which Justice Douglas enunciated that individuals have a right to be left alone without the intrusion of government. Justice Douglas, writing for the majority in Griswold, authorized judicial intervention into state legislative action and created a separate and distinct right of privacy. Although not explicitly mentioned in the Bill of Rights, he said "the Bill of Rights have penumbras, formed by emanations from those guarantees that help

13. Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891). This was a civil action for an injury to a person. Id. The Court considered the single question whether the trial court, in advance of trial, may order the plaintiff, without consent, to submit to a surgical examination as to the extent of the injury sued for. Id.
give them life and substance.'\textsuperscript{17} However, in the same decision, he also said, "We do not sit as a super-legislature to determine the wisdom, need and propriety of laws that touch economic problems, business affairs or social conditions."\textsuperscript{18} This right of privacy, created within the penumbra of the First Amendment and applied to the states through the Fourteenth Amendment, was the adoption and extension of Justice Brandeis' dissent in \textit{Olmstead}.

Since \textit{Griswold}, there has been no question but that a competent adult has the right to refuse medical treatment.\textsuperscript{19} The difficulty arises when a decision must be made where a person was once competent but is now incompetent, and has never expressed an opinion concerning the invasion of that right of privacy with a life support system or the cessation of that life support system, as in the case of \textit{In re Quinlan}\textsuperscript{20} or where a person once competent and now incompetent has previously expressed an opinion, as in the case of \textit{In re Storar}\textsuperscript{21}. The decision making process becomes even more difficult when the situation involves a person who was never competent, as in the case of \textit{Superintendent of Belchertown State School v. Saikewicz}\textsuperscript{22}.

The question of who shall speak for the incompetent to exercise the right to refuse or withdraw invasive life prolonging technology through forced nutrition and hydration, where the use of the technology does not provide a reasonable hope of any benefit to the patient in treating the underlying illness, has been considered in a number of cases. In \textit{Superintendent of Belchertown State School v. Saikewicz}\textsuperscript{23} the court framed the issue as how an incompetent person\textsuperscript{24} is to be afforded the status in law of a competent person with respect to the right to decline potentially life-prolonging treatment.\textsuperscript{25} After stating that the issue was one of first impression.

\begin{itemize}
\item \textsuperscript{17} \textit{Id.} at 484.
\item \textsuperscript{18} \textit{Id.} at 482.
\item \textsuperscript{22} \textit{Superintendent of Belchertown State School v. Saikewicz}, 373 Mass. 728, 370 N.E.2d 417 (1977).
\item \textsuperscript{23} \textit{Id.}
\item \textsuperscript{24} Joseph Saikewicz was a resident of the state school. He was 67 years old, with an I.Q. of 10 and mental age of approximately two years and eight months. He was suffering from a fatal form of leukemia. He was unable to communicate verbally, and was unable to respond to inquiries as to whether he was experiencing pain. \textit{Id.} at 731, 370 N.E.2d at 420.
\item \textsuperscript{25} \textit{Id.} at 734, 370 N.E.2d at 423.
\end{itemize}
before the court, the concept of substituted judgment expressed in
*In re Quinlan*, was extensively reviewed. Although the *Saikewicz*
court criticized the procedure set forth in *Quinlan*, it nevertheless
adopted the concept of substituted judgment. The persons to
whom the court granted the right to substitute judgment were stran-
gers to Joseph Saikewicz.

The court in *Saikewicz* stated its task of “establishing a frame-
work in the law on which the activities of health care personnel and
other persons can find support is furthered by seeking the collective
guidance of those in health care, moral ethics, philosophy, and other
disciplines.” In the penultimate paragraph of its opinion, the court
concluded

> We do not view the judicial resolution of this most difficult and awe-
some question — whether potentially life-prolonging treatment should
be withheld from a person incapable of making his own decision—as
constituting a “gratuitous encroachment” on the domain of medical
expertise. Rather such questions of life and death seem to us to re-
quire the process of detached but passionate investigation and deci-
sion that forms the ideal of which the judicial branch of government
was created . . . and is not to be entrusted to any other group purport-
ing to represent the “morality and conscience of our society,” no mat-
ter how highly motivated or impressively constituted.

The case of *In re Eichner* involved the question of a person,
once competent and now incompetent, having expressed views prior
to becoming incompetent as to the use of technology to prolong
life. Father Eichner, director of a Catholic religious order, applied
to the court to remove a respirator from Brother Fox, a member of

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27. The *Quinlan* court established a procedure whereby a decision on with-
drawal of life support systems may be made by Karen’s guardian, family, attending
physicians, and the hospital “ethics committee”. *Quinlan* at 54, 355 A.2d at 671.

28. *Saikewicz*, 373 Mass at 745, 370 N.E.2d at 434 (court-appointed guardian
and probate judge to exercise substituted judgment for incompetent).

29. *Id.* at 733, 370 N.E.2d at 422.

30. *Id.* at 46, 370 N.E.2d at 435.

31. *In re Eichner*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S. 266, cert. denied

32. Father Eichner was the director of the Society of Mary, a Catholic religious
order, and maintained a residence for members of the Society. Brother Fox, an 83
year old member of the Society of Mary, was in good health. During the course of an
uncomplicated surgical operation, he suffered cardiac arrest resulting in substantial
brain damage. He was placed on a respirator in a permanent vegetative state. The
attending physicians advised that there was no reasonable chance of recovery. Father
Eichner requested the hospital to remove the respirator. The hospital refused. Father
Eichner applied to the court for authority to direct the removal of the respirator. The
court appointed a guardian ad litem, and directed that notice be served on all inter-
ested parties, including the District Attorney. At the hearing, all experts agreed that
there was no reasonable likelihood that Brother Fox would ever emerge from the veg-
etative coma or recover his cognitive powers. *Id.* at 370-71, 420 N.E.2d at 67-68, 438
N.Y.S.2d at 269-70.
the order who had suffered brain damage during a surgical operation. Evidence was adduced at a hearing that Brother Fox had publicly expressed an opinion on several occasions that he would not want his life prolonged by extraordinary life support systems when there is no reasonable hope for recovery. The court held that the wishes of Brother Fox expressed prior to his becoming incompetent should be honored.\textsuperscript{33} Therefore, an appropriate person should be appointed to express that right on behalf of Brother Fox by use of substituted judgment. The court established an elaborate set of procedures to be followed by doctors, hospitals, family members, the court, and others.\textsuperscript{34}

At the time the reviewing court heard \textit{In re Eichner}, it heard as a consolidated matter the case of \textit{In re Storar},\textsuperscript{35} where the facts were somewhat different. John Storar had never been competent.\textsuperscript{36} He had terminal cancer of the bladder, which caused a loss of blood. Although the blood could be replaced by transfusions, the transfusions would not cure the cancer. There was also evidence that John Storar found the transfusions disagreeable, and required a sedative before each transfusion.\textsuperscript{37} John's mother, who had been appointed guardian of his person and property, requested that the transfusions be discontinued. The director of the state facility refused. On the basis that the transfusions could not cure the disease, involved some pain, and that the patient submitted to them reluctantly, the court denied the state facility's application for permission to continue the transfusions. The court further held that a person has a right to determine what will be done to his own body and when he is incompetent that right may be exercised by the "substituted judgment" of another on his behalf. John Storar's mother was the person in the best position to determine what John Storar would want. Her petition was granted.\textsuperscript{38}

In both \textit{Storar} and \textit{Eichner}, the District Attorney urged that the patient's right to decline medical treatment is outweighed by

\begin{footnotesize}
\begin{itemize}
\item[33.] \textit{Id.} at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.
\item[34.] \textit{Id.}
\item[36.] He was 52 years old, but had a mental age of about 18 months. He had been a resident of a state facility since the age of 5. His closest relative was his mother, a 77 year old widow. \textit{Id.} at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.
\item[37.] When the cancer was first suspected, Mrs. Storar consented to diagnostic tests, transfusions, and radiation therapy. At a later time, however, she requested that the transfusions be discontinued. Her request was refused. \textit{Id.} at 373, 420 N.E.2d at 68-69, 438 N.Y.S.2d at 271.
\end{itemize}
\end{footnotesize}
state interests when the treatment is necessary to preserve the patient's life. The District Attorney further urged that there is no basis for substituted judgment once a patient becomes incompetent. The court may appoint a guardian to manage the incompetent's financial affairs and to supervise his person, but the right to refuse medical treatment is so entirely personal that it should not be exercised by a representative of the incompetent. In the reviewing court the District Attorney also argued that in *Eichner* the petition by the alleged representative of the incompetent did not present a justiciable controversy, but rather called for "innovations in the law, both substantive and procedural, which should be left to the Legislature, subject only to review by the courts for compliance with constitutional requirements."

The state, even in the face of the protected right to privacy, has the power to act when there is a compelling state interest. The constitutional and common law right to refuse medical treatment must be balanced against competing governmental interests. Courts have identified a compelling state interest in: (1) preserving life, (2) preventing suicide, (3) protecting the integrity and interests of other patients and third parties, and (4) safeguarding the integrity of the medical profession.

The first of the compelling state interests - the preservation of life - is generally considered the most important. The state's interest in preserving life weakens, however, and must yield to the patient's interest where the medical treatment in question "serves only to prolong a life inflicted with an incurable condition."

The second state interest which may override the right of a competent to refuse medical treatment is the prevention of suicide. However, "[a] death which occurs after the removal of life-sustaining systems is from natural causes, neither set in motion nor in-

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40. See, e.g., *Roe v. Wade*, 410 U.S. 113, reh'g denied, 410 U.S. 959 (1973) (at some point in a pregnancy, the interest of the state in the woman's health and in the fetus become compelling, and limit a woman's right to terminate the pregnancy); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (state interest in family allows court to deny an immature minor's request for an abortion). See also *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr 297 (1986) (competent although physically disabled patient with no underlying illness could not compel the hospital facility to assist her in terminating her own life while relieving her pain).
tended by the patient and therefore is not suicide.”

The third state interest involves the protection of the interests of third parties such as minor or dependent children. This interest frequently arises in Jehovah’s Witness cases, for example, where a pregnant woman refuses a blood transfusion, and the court finds a compelling state interest to protect the unborn child. Similarly, a court ordered blood transfusions for a nonconsenting Jehovah’s Witness who was the mother of three minor children, reasoning that if she died, the children might become wards of the state.

The final state interest is safeguarding the integrity of the medical profession. The American Medical Association, through its Council on Ethical and Judicial Affairs, in its statement of March 15, 1989, expressed its opinion that life prolonging medical treatment includes nutrition and hydration and “the physician should determine whether the benefits of treatment outweigh its burdens.”

Judicial intervention in withholding or withdrawing nutrition and hydration suggests that it is appropriate for the judiciary, created and designed to resolve justiciable issues, to actively intrude upon the right of privacy emanating from the Bill of Rights of the Constitution. Judicial intervention results in the overlaying of the moral principles of an individual judge or a panel of reviewing court judges upon the right of individuals to make their own decisions. The intrusion of individual judges, imposing their individual moral principles, is judicial activism attempting to create a duty and right for every difficult decision by members of various communities and societies.

44. Id.
45. Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson, 42 N.J. 421, 201 A.2d 537, cert. denied 377 U.S. 985 (1964). The court authorized blood transfusions for a nonconsenting Jehovah’s Witness who was pregnant, saying that the life of the mother was so inextricably interwoven with that of the child as to render it impracticable to distinguish between them. The court used the term “quick with child.” This could precipitate a further question in view of the current state of the law in the trimester analysis of abortion cases.
46. Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir. 1964), cert. denied 377 U.S. 978 (1964). But see In re Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965), where the Illinois Supreme Court, finding that no minor children were involved, reversed the trial court which had ordered transfusions.
48. See supra note 8, penultimate sentence in the final paragraph.
The justification espoused for such activism is frustration with the failure of other branches of our tripartite form of government and organized societies to reach a consensus on what is acceptable moral conduct. Oliver Wendell Holmes, Associate Justice of the United States Supreme Court, was troubled by judicial activism imposing its own moral notions on the law. The judicial branch of government in the United States was created from the desire of its citizens to live in organized communities in a society under law, a law based upon public policy established by the participation of its citizens. In such a society, the legislature establishes public policy.

WHAT IS THE ROLE OF A COMMUNITY OR SOCIETY IN DETERMINING WHETHER TO WITHHOLD OR WITHDRAW NUTRITION AND HYDRATION

Communities are voluntary associations of people who share common interests and a common view of what is morally acceptable. The community maintains that attitude when joining with other communities in pursuit of important goals. Society is the combination of various communities of people with different acceptable moral principles, joining together to pursue those important goals. Society exists and survives because various communities that have joined together, for whatever reason, compromise some, but not all, of their community views. The communities themselves may share a common view of good, but our existing pluralistic society lacks consensus in a singular acceptable moral belief. One community may find particular conduct acceptable, yet another community may find that same conduct unacceptable.

The first consideration to achieve a moral result must be whether a society will accept as supreme and final a decision about particular conduct. The second consideration is that similar situations, and in the case of judicial decisions similar circumstances, will be treated in the same or reasonably similar ways.

The present ad hoc decisions from the several states which have attempted to resolve the ambiguity of judicial intervention in withholding or withdrawing nutrition and hydration appear to be unacceptable to some communities within the society, otherwise, there would not be the existing difficulty and differences in determining


51. See L.S. Rothenberg, Demands for Life and Requests for Death: The Judicial Dilemma, in Death and Decision 131 (1978). Rothenberg examines a number of cases in which judges without any legislative guidance, have expressed their attitudes, anguish and ambivalence as decision-makers in right to die cases.
an appropriate and acceptable course of conduct. It is clear that
similar situations and cases are not treated in the same or even a
reasonably similar way.

Society must attempt to formulate and define a standard of
course from which a judicial determination may be made in an ad-
dversarial proceeding. It is the standard of conduct which dictates
whether actions of a particular kind should be done because they are
right or wrong. It is then the job of the judge to apply the law, the
standard of conduct, upon facts developed through the truth seeking
process by presentation of evidence in an adversarial forum.

That standard of conduct is called public policy and is generally
based upon concepts of a good life, the nature of rights and duties,
costs, resource management, and the compromise of competing inter-
ests. Public policy should not be left to an individual judge, or
even a panel of reviewing judges, imposing individual moral stan-
dards upon the community at large.

The judicial process is incapable of negotiating compromises
among communities and societies to resolve moral dilemmas, and is
incapable of establishing public policy as a moral standard of soci-
ety. Public policy and moral standards are best determined and enun-
ciated through the legislative process. Legislation should ad-
dress (1) what constitutes medical treatment; (2) who should decide
for those patients who have not previously expressed their wishes
concerning the extent of care; (3) when court intervention is appro-
priate; and (4) the minimum standard of care for which no criminal
or civil liability will attach.\footnote{Two bills were recently introduced in the Illinois Senate addressing these
issues. The proposed Health Care Consent Act, drafted by the Illinois Hospital Asso-
ciation, is a reaction to a recent Illinois Supreme Court decision, \textit{In re} Estate of
Longeway. See infra notes 72-84 and accompanying text for a discussion of
\textit{Longeway}.}

\begin{verbatim}
Senate Bill 1887 provides:
\textit{Be it enacted by the People of the State of Illinois, represented in the Gen-
eral Assembly:}

Section 1. Title. This Act shall be known and may be cited as the Health Care
Consent Act.

Section 2. Definitions. As used in this Act:
(a) "Adult" means an individual 18 years of age or older.
(b) "Attending physician" means the physician, licensed in the state of Illinois,
who has primary responsibility for an individual's health care. If more than
one physician shares such responsibility, any such physician may act as the
attending physician.
(c) "Consent" means to give consent to, authorize, refuse, or withhold or with-
draw consent to health care.
(d) "Health care" means any care, treatment, service, or procedure to main-
tain, diagnose, treat, or provide for an individual's physical or mental health or
personal care, and includes any life-sustaining care.
(e) "Health care provider" or "provider" means a person that is licensed, certi-
fied, or otherwise authorized by the law of this State to provide health care.
\end{verbatim}
"Life-sustaining care" means any care, treatment, procedure or intervention which, in the judgment of the attending physician, when provided to a person with a qualifying condition, would not remove the qualifying condition, would be futile, or would serve only to prolong the dying process. "Life-sustaining care" includes, but is not limited to, assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration.

"Minor" means an individual who is not an adult.

"Parent" means the father or mother of a legitimate or illegitimate child, including any adoptive parent, but not a parent whose rights with respect to the child have been terminated.

"Patient" means an individual requesting or receiving health care from a health care provider.

"Person" means an individual, corporation, partnership, association, trust, or any other legal entity.

"Qualifying condition" means

1. an incurable and irreversible condition which is such that the provision of health care serves only to prolong the dying process; or
2. a coma or other neurological condition which, to a high degree of medical certainty, will last indefinitely without improvement and in which the patient
   i. shows no evidence of verbal or non-verbal communication,
   ii. demonstrates no purposeful movement or motor ability,
   iii. is unable to interact purposely with stimulation provided by his environment.

Section 3. Individuals Who May Consent To Health Care. Unless incapable of consenting under Section 4 of this Act, an individual may consent to health care on his or her own behalf if he or she is:

a. an adult; or
b. A minor who:
   i. is married,
   ii. is pregnant,
   iii. is a parent,
   iv. is in the military service of the United States,
   v. is emancipated pursuant to the Emancipation of Mature Minors Act, subject to any limitations imposed by the order of emancipation,
   vi. is authorized to consent to health care under any other law of this State.

Section 4. Individuals Incapable of Consenting. An individual authorized under Section 3 of this Act may consent to his or her own health care unless, in the good faith opinion of the health care provider that would render the proposed health care, the individual is incapable of making an informed decision regarding the proposed health care.

Section 5. Individuals Who May Consent to Health Care for Others.

a. Subject to the provisions of subsection (c) below regarding the withholding or withdrawing of life-sustaining care, when an individual otherwise authorized to consent to his or her own health care under Section 3 is determined to be incapable of consenting under Section 4, any of the following persons in the order of priority stated and in the absence of actual notice to the provider of opposition by a person of a higher priority, may consent to health care on behalf of such individual, when persons of higher priority are not available:
   i. a court-appointed guardianship, within the authority of the guardianship;
   ii. the individual's spouse;
   iii. the individual's eldest available adult son or daughter;
   iv. either of the individual's parents;
   v. the individual's eldest available adult brother or sister; or
(6) the individual’s eldest available adult grandchild.

A health care provider shall not be obligated to seek the appointment of a guardian when none exists.

(b) Subject to the provisions of subsection (c) below regarding the withholding or withdrawing of life-sustaining care, and unless otherwise precluded by law, consent to health care for a minor not authorized to consent under Section 3 may be given:

(1) by either parent, including a parent who is a minor; or
(2) by the minor’s court-appointed guardian, within the authority of the guardianship.

(c) A person authorized to consent to health care on behalf of another under this Section shall have the authority to consent to the withholding or withdrawing of life-sustaining care under the following conditions:

(1) the patient has been diagnosed as having a qualifying condition;
(2) the determination under Section 4 that the patient is incapable of consenting shall be made by the attending physician and at least one other physician who has personally examined the patient in writing in the patient’s medical record and shall include the physicians’ opinions regarding the cause, nature, and indefinite duration of the patient’s inability to consent;
(3) the existence of a qualifying condition shall be documented by the attending physician and at least one other physician who has personally examined the patient in writing in the patient’s medical record and shall include its cause and nature, if known; (4) the consent to withhold or withdraw life-sustaining care shall be in writing in the patient’s medical record, shall be dated and signed by the person giving consent in the presence of one disinterested witness who shall also sign, and shall relate the substance of the discussion leading to the decision to withhold or withdraw life-sustaining care; and
(5) when the patient is a minor not authorized to consent under Section 3, both parents, if available, must consent to the withholding or withdrawing of life-sustaining care.

(d) For purposes of this Section, a person is not “available” if:

(1) the existence of the person is not known to the provider and is not readily ascertainable through an examination of the patient’s records or by questioning any persons who are available;
(2) the provider has unsuccessfully attempted to contact the person by mail, telephone or other reasonable means;
(3) the person is unwilling to respond in a manner which indicates either consent or refusal to consent to the proposed health care; or
(4) the person is incapable of consenting under Section 4 of the Act.

A determination that a person is not available under subsections (2), (3), or (4) above shall be documented in the patient’s medical record.

Section 6. Court-Ordered Health Care or Court-Ordered Appointment of a Guardian.

(a) A health care provider or any individual with a direct interest may petition a court of competent jurisdiction to (i) make a health care decision or order health care for an individual incapable of consenting or (ii) appoint a guardian to act for that individual.

(b) The court may modify or dispense with notice and hearing if it finds that delay will have a serious, adverse effect upon the health of the individual.

(c) The court may order health care, appoint a guardian to make a health care decision for the individual incapable of consenting to health care (with such limitations on the authority of the guardian as it considers appropriate), or order any other appropriate relief, if it finds:

(1) a health care decision is required on behalf of the individual;
(2) the individual is incapable of consenting to health care; and
(3) there is no individual authorized to consent or an individual authorized to consent to health care is not available pursuant to Section 5(d), declines to act, or is not acting in the best interest of the individual in need of health care.

Section 7. Limitations of Liability.
(a) A health care provider that relies upon the consent or refusal of consent of an individual who the provider believes in good faith is authorized by this Act or other law of this State to consent to health care is not subject to criminal prosecution, civil liability, or professional disciplinary action on the ground that the individual who consented or refused to consent lack authority or capacity.

(b) A health care provider who believes in good faith an individual is incapable of consenting under Section 4 is not subject to criminal prosecution, civil liability, or professional disciplinary action for failing to follow that individual's direction.

(c) A person who in good faith believes he is authorized to consent or refuse to consent to health care for another under this Act or other law of this State is not subject to criminal prosecution or civil liability on the ground that he lack authority to consent.

Section 8. Availability of Medical Information. An individual authorized to consent to health care for another under this Act has the same right as does the individual for whom he is acting to receive information relevant to the contemplated health care and to consent to the disclosure of medical records to a health care provider. Disclosure of information regarding contemplated health care to an individual authorized to consent for another is not a waiver of any evidentiary privilege.

Section 9. Effect on Existing State Law.
(a) This Act does not affect the requirements of any other law of this State concerning consent to observation, diagnosis, treatment, or hospitalization for a mental illness.

(b) This act does not affect the law of this State concerning (i) the standard of care required of a health care provider in the administration of health care, (ii) the circumstances under which consent is or is not required for health care, (iii) the elements of informed consent for health care, (iv) consent to health care in an emergency, or (v) the right of a health care provider to refuse to perform any act that is contrary to the conscience or philosophy of the provider.

(c) This Act shall not apply when the health care provider has actual knowledge that the patient has a living will and that the patient is a “qualified patient” under the Living Will Act.

(d) This Act shall not apply when the health care provider has actual knowledge that the patient has appointed a health care agent under the Powers of Attorney for Health Care Law and such agent is available pursuant to Section 5(d) of this Act.

Section 10. Severability. If any provisions of this Act or the application hereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or application of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

The Health Care Consent Act, S.B. 1887, 86th General Assembly, (Apr. 5, 1990). Senate Bill 1887 was still in the Senate Judiciary Committee when the legislative session ended.

The second bill is the Decisions to Forego Life-Sustaining Treatment Act. This bill is the result of a study done by the Cook County (Illinois) States Attorney's Task Force. This task force was created to examine the issues of removal of life support systems after a young father held hospital personnel at
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In a gunshot incident, he removed the respirator from his comatose 15-month-old son.

Senate Bill 2213 provides:

AN ACT in relation to private decision making to forego life-sustaining treatment.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Decisions to Forego Life-Sustaining Treatment Act.

Section 2. Legislative findings and purposes.

(a) Findings.

The legislature finds that all persons have a fundamental right to make decisions relating to their own medical treatment, including the right to forego life-sustaining treatment.

Lack of decisional capacity, alone, should not prevent decisions to forego life-sustaining treatment from being made on behalf of persons who lack decisional capacity and have no known effective living will or durable power of attorney for health care.

Uncertainty and lack of clarity in the law concerning the making of private decisions (without judicial intervention) to forego life-sustaining treatment causes unnecessary emotional distress to the individuals involved.

The enactment of statutory guidelines for private decision making will bring clarity and certainty and will substantially reduce the associated emotional distress for involved parties.

The provisions of this Act shall not be applicable when a patient has an operative and unrevoked living will under the Living Will Act or a durable power of attorney for health care under the Power of Attorney Act. In the event an unrevoked advance directive, however, such as a living will or a power of attorney for health care, is no longer valid due to a technical insufficiency, that document may be used in conjunction with this Act as evidence of prior intent.

Except as specifically expressed in this Act, this Act is not intended to abrogate the physician's traditional common law right to determine which treatment options are appropriate under a certain set of circumstances or to affect the common law doctrine of informed consent. Further, nothing in this Act abrogates the right of an adult patient with decisional capacity to make his or her own decisions regarding foregoing life-sustaining treatment. Moreover, nothing in this Act purports to supersede federal regulations regarding the treatment of neonates.

The withholding or withdrawal of life-sustaining treatment from a patient in accordance with this Act does not, for any purpose, constitute suicide or murder. Nothing in this Act, however, shall be construed to condone, authorize, or approve mercy killing or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this Act.

(b) Purposes.

This Act is intended to define the circumstances under which private decisions by patients with decisional capacity and by surrogate decision makers on behalf of patients lacking decisional capacity to determine life-sustaining treatment may be made without judicial involvement of any kind.

This Act is intended to establish a process for that private decision making.

This Act is intended to clarify the rights and obligations of those involved in those decisions by or on behalf of patients.

This Act is intended to provide for criminal immunity for those involved in the decisional process established by this Act.
Section 3. Definitions.

"Adult" means a person who is 18 years of age or older or an emancipated minor.

"Artificial nutrition and hydration" means supplying food and water through a conduit, such as a tube or intravenous line, where the recipient is not required to chew or swallow voluntarily, including, but not limited to, nasogastric tubes, gastrostomies, and intravenous infusions. Artificial nutrition and hydrations does not include assisted feeding, such as spoon or bottle feeding.

"Attending physician" means the physician selected by or assigned to the patient who has primary responsibility for the treatment and care of the patient and who is a licensed physician in Illinois. If more than one physician shares that responsibility, any of those physicians may act as the attending physician under this Act.

"Close friend" means any person 18 years of age of[sic] older who presents an affidavit to the attending physician stating that he or she is a close friend of the patient and has maintained such regular contact with the patient as to be familiar with the patient's activities, health, religious and moral beliefs and stating the facts and circumstances that demonstrate that familiarity.

"Death" means (i) when, according to customary medical practice, there is an irreversible cessation of heartbeat and respiration or (ii) when there is an irreversible cessation of total brain function.

"Decisional capacity" means the ability to understand and appreciate the nature and consequences of a decision regarding foregoing life-sustaining treatment and the ability to reach an informed decision in the matter.

"Domestic partners" means 2 unmarried, unrelated adults who have formed a committed relationship whereby they live together and share the common necessities of life.

"Forego life-sustaining treatment" means to withhold, withdraw, or terminate all or any portion of life-sustaining treatment with knowledge that the patient's death is an expected result.

"Guardian" means a court appointed guardian of the person who serves as a representative of a minor or as a representative of a person under legal disability.

"Health care provider" means a person, individual, corporation, business trust, trust, partnership, association, government, governmental subdivision or agency, or any other legal entity that is licensed, certified, or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession.

"Imminent" (as in "death is imminent") means a determination made by the attending physician on a case-by-case basis that death is about to take place, even if life-sustaining treatment is initiated or continued.

"Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a patient with a qualifying condition, would not be effective to remove the qualifying condition, would be futile, or would serve only to prolong the dying process. Those procedures include, but are not limited to, assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration.

"Minor" means an unemancipated or unmarried person under the age of 18 years.

"Parent" means a person who is the natural or adoptive mother or father of the child and whose parental rights have not been terminated by a court of law.

"Patient" means a person under the care of a licensed physician.
“Qualifying condition” includes the existence of one or more of the following conditions in a patient confirmed in writing by the attending physician in the patient's medical chart and certified in writing in the patient's medical chart by at least one other qualified physician:

1. “Terminal condition” means an illness or injury for which there is no reasonable prospect of cure or recovery, death is imminent, and the application of life-sustaining treatment would only prolong the dying process.

2. “Permanent unconsciousness” means a condition that, to a high degree of medical certainty, will last permanently without improvement and in which thought, sensation, purposeful action, social interaction, and awareness if self and environment are absent, including, but not limited to, conditions referred to a persistent vegetative state and irreversible coma.

3. “Extraordinary burdensomeness” means that to continue or to apply life-sustaining treatment would impose an extraordinary financial or personal burden on a non-terminal patient, and the treatment, in light of the patient's medical condition, would provide only minimal medical benefit.

“Qualified physician” means a physician licensed to practice medicine in Illinois who has personally examined the patient.

“Surrogate decision maker” means an individual who has decision making capacity and who is identified as the person who is to make the decisions regarding the foregoing of life-sustaining treatment on behalf of a patient who lacks decisional capacity and is diagnosed as suffering from a qualifying condition.

Section 4. Non-application. This Act does not apply to instances in which the patient has an operative and unrevoked living will under the Living Will Act or a durable power of attorney for health care under the Power of Attorney Act and the patient's condition falls within the coverage of the Living Will Act or the Power of Attorney Act. In those instances, the living will or durable power of attorney for health care, as the case may be shall be given effect according to its terms. This Act does not apply to patients without a qualifying condition.

Section 5. Private decision making process.

(a) Decisions whether to forego life-sustaining treatment involving an adult patient with decisional capacity may be made by that adult patient.

(b) Decisions whether to forego life-sustaining treatment on behalf of a patient without decisional capacity and who has a qualifying condition, without resort to the courts or legal process, are lawful if the decisions are made in accordance with one or more of the following paragraphs (1), (2), or (3) and otherwise meet the requirements of this Section:

1. Decisions whether to forego life-sustaining treatment involving an adult patient who lacks decisional capacity may be made by a surrogate decision maker in consultation with the attending physician, as provided in Section 6.

2. Decisions whether to forego life-sustaining treatment involving a patient who is a minor may be made by the minor's adult parent or parents or guardian in consultation with the attending physician and in accordance with the child's best interests.

3. Decisions whether to forego life-sustaining treatment involving a patient who is an adult and who lacks decisional capacity, but without any surrogate decision maker being available as determined after reasonably diligent inquiry by the attending physician, may be made by the health care facility's ethics consult service or by a court appointed guardian. The consult service or guardian shall make the decision on the basis of the patient's wishes, including a consideration of the patient's religious and moral beliefs. If the patient's wishes are unknown and remain unknown after reasonably diligent efforts to
discern them, the decision may be made on the basis of the patient's best interests as determined by the consult service or the guardian. The ethics consult service shall consist of a balanced mix of physicians, nurses, lawyers, ethicists, and clergy persons, a majority of whom are not otherwise affiliated with the relevant health care facility.

(c) A determination that an adult patient lacks decisional capacity shall be made by the attending physician to a reasonable degree of medical certainty. The determination shall be in writing in the patient's medical record and shall set forth the attending physician's opinion regarding the cause, nature, and indefinite duration of the patient's lack of decisional capacity. At least one other qualified physician must concur in the determination that an adult patient lacks decisional capacity. The concurring determination shall be made in writing in the patient's medical record after personal examination of the patient. The concurring determination shall contain that physician's opinion regarding the cause, nature, and indefinite duration of the patient's lack of decisional capacity.

(d) The attending physician shall record in the patient's medical chart the fact that the patient, the surrogate decision maker, or the guardian has made a decision to forego life-sustaining care and the substance of the discussion that led up to the decision.

(e) The existence of a qualifying condition shall be documented in writing in the patient's medical chart by the attending physician and shall include its cause and nature, if known. The written concurrence of another qualified physician is also required.

(f) In the event of a patient's death, all life-sustaining treatment and other medical care may be terminated.

(g) If the attending physician believes that a surrogate decision maker or guardian is not acting according with his or her responsibilities under this Section and Section 6, the physician shall invoke the dispute resolution mechanisms provided in Section 7.

Section 6. Surrogate decision making.

(a) An adult surrogate or surrogates from the following list, to be chosen in order of priority listed, who have decisional capacity, are available upon a reasonably diligent inquiry, and are willing to make a decision whether to forego life-sustaining treatment on behalf of a patient with a qualifying condition who lacks decisional capacity, shall be authorized to make those decisions on behalf of the patient in the following order:

(1) the patient's guardian;
(2) the individual or individuals clearly identified by the patient while the patient was competent;
(3) the patient's spouse;
(4) the adult sons and daughters of the patient;
(5) an adult son or daughter of the patient who has the waiver and consent of all other qualified adult sons and daughters of the patient to act as the sole surrogate decision maker;
(6) the parent or parents of the patient;
(7) a parent of the patient who has the waiver and consent of the other parent of the patient to act as the sole surrogate decision maker;
(8) the adult brothers and sisters of the patient;
(9) an adult brother or sister of the patient who has the waiver and consent of the other adult brothers and sisters of the patient to act as the sole surrogate decision maker;
(10) the adult grandchildren of the patient;
(11) an adult grandchild of the patient who has the waiver and consent of the other adult grandchildren of the patient to act as the sole surrogate deci-
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(12) a close friend of the patient.

Where there are multiple surrogate decision makers at the same priority level in the hierarchy, it shall be the responsibility of these surrogates to make reasonable efforts to reach a consensus as to their decision on behalf of the patient regarding the foregoing of life-sustaining treatment.

(b) In the event an individual in an inferior priority level seeks to challenge the authority of an individual in a superior authority level to act as surrogate decision maker, the challenging individual may proceed under the dispute resolution mechanism set forth in Section 7.

(c) After a surrogate has been identified, the name and relationship of that person to the patient shall be included in the patient's medical record. A surrogate decision maker shall make his or her decision on the basis of the patient's wishes, including, but not limited to, a consideration of the patient's religious and moral beliefs. If the patient's wishes are unknown and remain unknown after diligent efforts to discern them, the decision may be made on the basis of the patient's best interests as determined by the surrogate decision maker.

(d) The surrogate decision maker shall have the same right as the patient to receive medical information and medical records.

(e) A surrogate decision maker shall express his or her decision to forego life-sustaining treatment on behalf of the patient in writing. The writing shall be dated and signed in the presence of one witness who is 18 years of age or older and who shall also sign. A copy of the properly executed decision shall be included in the patient's medical record. Once the provisions of this Act are complied with, the attending physician may thereafter promptly implement the decision to forego life-sustaining treatment on behalf of the patient unless he or she has actual knowledge of a dispute or disagreement among the permitted surrogate decision makers set forth in subsection (a) or is unable to do so for conscientious reasons, in which event Section 9 shall apply.

Section 7. Dispute resolution mechanism.

(a) Each hospital or other health care facility licensed by the State of Illinois shall establish a mechanism for the purpose of mediating and resolving, whenever possible, disputes regarding decisions to forego life-sustaining treatment. Existing hospital resources may be utilized, such as a chaplain's office, a patient's representative office, or a medical ethics committee. In the alternative, a new mechanism may be created especially for this purpose. The role of this mechanism shall be advisory only. It shall have no authority to make a decision whether or not to forego life-sustaining treatment. No action to implement a decision to forego life-sustaining treatment shall be taken for the next 72 hours following the submission of the dispute to the mechanism.

(b) The dispute resolution mechanism shall be described in writing and shall be approved by the facility's governing body. The policy establishing the mechanism shall provide for written submission of the dispute to the administrator of the health care facility or his or her designated representative. The policy shall also provide for reasonable notice to the parties involved in the decision making process, including all appropriate surrogate decision makers.

(c) After 72 hours have elapsed from the submission of the dispute, if the dispute remains unresolved, the attending physician, the hospital or other health care facility, or both may lawfully transfer the patient to another physician or hospital or other health care facility willing to accept the patient.

(d) In the event judicial review of a dispute is sought before a court of competent jurisdiction, the person or entity challenging the advisory opinion of the dispute resolution mechanism must show by clear and convincing evidence that it is contrary to the patient's wishes or best interests.

Section 8. Immunity.
There is criticism that the legislative process is too cumbersome and incapable of responding to immediate needs. Speed, however, may not be appropriate when the moral fiber of a community is at stake.

The withholding or withdrawal of nutrition and hydration is biologically fatal. There is no known way to continue to live without both food and water. Death is the universal consequence of a lack of either or both. Medical treatment in all of its meaning is to treat the ill condition of a human being. There is no ill condition of a human being that is being medically treated by withholding or withdrawing nutrition and hydration. Assisted feeding is, therefore, dissimilar to other assisted life prolonging procedures.

THE CHALLENGE TO SOCIETY IS TO DETERMINE WHEN DEATH OCCURS

Vex not his ghost; 0! let him pass; he hates him
That would upon the rack of this tough world
Stretch him out longer.33

(a) No physician, other health care professional, hospital, or other health care facility or any of their employees, officers, directors, agents, or persons under contract with them shall be subject to any criminal prosecution or be deemed to have engaged in unprofessional conduct for carrying out in good faith and in accordance with this Act and reasonable medical standards a decision to forego or not to forego life-sustaining treatment by or on behalf of a patient with or without decisional capacity. The same immunity applies to a physician who for conscientious reasons under Section 9 is unable to comply with a decision to forego life-sustaining care.

(b) No person shall be subject to any criminal prosecution for making a decision to forego or not to forego life-sustaining treatment in good faith on behalf of a patient who lacks decisional capacity in accordance with this Act.

(c) No person shall be subject to any criminal prosecution for acts performed in good faith while participating in the dispute resolution mechanism described in Section 7.

(d) For the purposes of this Section, good faith shall be presumed, and the presumption may be rebutted by a party asserting lack of good faith only by a showing based on clear and convincing evidence.

Section 9. Conscience of health care professional. A health care professional who because of personal beliefs or his or her conscience is unable to comply with the terms of a decision to forego life-sustaining treatment shall, without undue delay, so notify the administration of the health care facility. The administration shall then facilitate the timely transfer of the patient to another health care professional willing to comply with the wishes of the patient or the surrogate in accordance with this Act or, if necessary, arrange for the patient’s transfer to another facility designated by the decision maker.

Section 10. Neonates. Nothing in this Act supersedes the provisions of 45 C.F.R. 1340.15 concerning the provision of “appropriate” nutrition, hydration, and medication for neonates.

Section 11. Other legal rights. Nothing in this Act preempts or limits any other legal right to effect the withholding, withdrawal, or termination of any life-sustaining treatment.

Section 12. Presumed competence. For the purposes of this Act, a patient, guardian, or surrogate decision maker is presumed competent in the absence of actual notice to the contrary to authorize the withholding or withdrawal of life-
Society must be willing to accept the reality of death or when life no longer exists. A tension exists between society and the medical profession in some decisions to withhold or withdraw life prolonging or death denying treatment. The decision to withdraw or withhold treatment has a significant effect upon society and raises many concerns. Among these concerns are the emotional well being of close friends and family, quality of life, public policy, allocation of resources, inter-generational equity, cost containment, and organ transplants. Society must reach a resolution about the cessation of life, but that resolution becomes increasingly more difficult as technology continues to advance.

No person who lives will not know death. It is a natural consequence of the beginning of life. At one time in history there was little difficulty in determining when death occurred. Experience taught us that there was a time when everyone knew that life no longer existed. Death occurred with the cessation of the vital functions of respiration and circulation of blood. A person who no longer breathed and whose heart no longer beat was dead. “In the old days there was no plug. No life supporting premortem umbilical cord silently proclaimed the presence of a fellow human being surviving only by the grace of the physician’s technological defiance of nature. Doctors knew their place; their allegiance to life was nearly absolute, but they understood when death had won.”

The advance in medicine using highly sophisticated technology to maintain respiration, circulation, nourishment and hydration, vital organ functions through dialysis, transplant, and mechanical organs has enabled medical professionals in the practice of their art to maintain a body, prolonging life and denying the natural consequence of life, which is death. “Death no longer necessarily occurs at the instant the heart and lungs cease to function. In fact, the poten-

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53. W. SHAKESPEARE, KING LEAR, Act V, scene iii, line 315 (Earl of Kent commenting upon the condition of King Lear who is brokenhearted and apparently in extremis).

tial reversibility of loss of cardiopulmonary function makes it impossible ever to identify a precise moment of death."55

Dictionary definitions try to explain death as the permanent ending of all life in a person, animal, or plant.56 Myths and literature often portray death as an enemy of mankind, although many poets such as William Cullen Bryant in "Thanatopsis", Alfred Tennyson in "Crossing the Bar", and Robert Louis Stevenson in "Requiem" show a calm acceptance of death.57 Philosophers have described death as the absence of life or the inability to maintain an integrated activity.

Medicine has never been able to define death. It has been unable to identify a point in time when death occurs. In an attempt to reduce the uncertainty as to the cessation of life, a commission was created in 1968 at the Harvard Medical School, known as the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death. (hereinafter Ad Hoc Committee).58 The original title of the committee included "A Definition of Irreversible Coma."59 This indicated a great deal of confusion in the medical profession suggesting that "irreversible coma" and "death" were synonymous. Permanently unconscious persons are not dead. If the two terms are synonymous, there would be no need to concern ourselves with the use of respirators or naso-gastric tubes or any other external mechanical devices to sustain the vital functions of a patient.

Biologists distinguish living species from inanimate objects by four qualities:

(1) growth or the ability to enlarge in size,
(2) metabolism by which substances are taken in and converted biochemically to the organism's own tissue and cells while at the same time undergoing a continuous buildup and breakdown of its own substance,
(3) irritability or the capacity of the organism to be sensitive and to

56. "[T]he ending of all vital functions without the possibility of recovery either in animals or plants or any parts of them: the end of life". Webster’s Third New International Dictionary of the English Language Unabridged 581 (1981).
58. A. Tennyson, Crossing the Bar in POETIC AND DRAMATIC WORKS 753 (1898); W.C. BRYANT, Thanatopsis in A LIBRARY OF POETRY AND SONG 621 (1872); R.L. STEVENSON, Requiem in HOME BOOK OF VERSE 3485 (1928).
59. See supra note 11 for the committee’s definition of brain death.
respond to external and internal forces and objects, and
(4) reproduction under appropriate conditions to produce another
organism of the same specie.60

Every culture in western civilization, and particularly those cul-
tures developed out of a Judeo-Christian theology, has paid great
reverence to the sanctity of life. Such reverence continues to this
day. Theologians in the Judeo-Christian tradition considered the liv-
ing human organism as temporal existence. Death was a natural
event, the end of temporal existence, but life is everlasting to those
who confess faith in God. The book of Genesis sets forth God’s ad-
monition to Adam: “And the Lord God Commanded the man say-
ing, of every tree of the garden thou mayst freely eat; but of the tree
of knowledge of good and evil, thou shalt not eat of it; for in the day
that thou eatest thereof thou shalt surely die.”61 In the Letter of
Paul to the Romans, Paul said “For the wages of sin is death; but
the gift of God is eternal life through Jesus Christ, our Lord.”62 Sim-
ilarly, in his First Letter of Paul to the Corinthians, Paul said “[f]or
as in Adam all die, even so in Christ shall all be made alive.”63 Mark
Twain, commenting on death in Pudd’nhead Wilson, said “[w]hoever has lived long enough to find out what life is, knows how
deep a debt of gratitude we owe to Adam, the first great benefactor
of our race. He brought death into the world.”64

Any analysis to resolve the issue of when to prolong life or deny
death must begin with a determination by a decision maker of when
life no longer exists. Society, philosophy, medicine, biology, and the-
ology have all attempted to determine when death occurs. Legisla-
tive bodies have attempted to make that same determination. None
of the disciplines have been successful. The judiciary, being a disin-
terested objective tribunal, has been thrust into the decision making
process. The judiciary is designed to resolve justiciable controver-
sies. It is ill equipped to determine when life begins and similarly ill
equipped to determine when life ends. Disparate irreconcilable in-
terests have caused the judiciary to consider and participate in the
determination of when to prolong life or deny death. The judiciary
will be required to determine procedural protections for all those
persons involved with that human being whose existence could be or

60. See Life, 14 Collier’s Encyclopedia 621 (W. Halsey and B. Johnston, eds.
1986).
61. Genesis 2:16-17 (The New Oxford Annotated Bible, Revised Standard Ver-
sion, H.G. May & B.M. Metzger eds.).
62. Romans 6:23 (The New Oxford Annotated Bible, Revised Standard Version,
H.G. May & B.M. Metzger eds.).
63. 1 Corinthians 15:22 (The New Oxford Annotated Bible, Revised Standard
Version, H.G. May & B.M. Metzger eds.).
is being sustained by highly sophisticated medical technology during the last stages of life. The tension between society and the medical profession will continue to exist until society reconciles itself to accepting death as a natural consequence of life.

The judiciary has been called upon to participate in the process of consensus and deliberation without a clear expression of the public policy. A determination of public policy must be made concerning procedural protections for human beings whose existence could be or is being sustained by technological medical skills. Our pluralistic society lacks a consensus in one moral belief. We have, therefore, resorted to a system designed to resolve justiciable issues in an attempt to resolve moral issues.

WHAT IS THE ROLE OF MORALITY IN DETERMINING TO WITHHOLD OR WITHDRAW NUTRITION AND HYDRATION

The secular and religious communities within our society are unable to reach a moral consensus concerning withholding or withdrawing nutrition and hydration. The various communities of people that make up society have been unable to develop a public policy through medicine, science, philosophy, or theology to determine when death occurs. The medical community has developed and revised its definition of when life ceases to exist, and what constitutes medical treatment. The judiciary, as a result of the inability of society to express a condition to describe the finiteness of life, in some instances has extended its proper function of determining justiciable issues to include the authority to determine when life no longer exists or when the quality of life is inadequate and has no reason to continue to exist.

The professional disciplines of medicine and the judiciary are generally held in high esteem in our society. Each profession generally is accorded an acceptance of finality to its decisions. When confronted with contrary moral viewpoints, each attempts to balance the different viewpoints. But each is inadequate, based upon the limitation of its discipline, to resolve the moral ambiguity in withholding or withdrawing nutrition and hydration and, therefore, is unable to treat similar situations or cases in the same or reasonably similar ways. The patient, those responsible for the patient, and the institutions that provide care for a patient, are unsure of an appropriate course of action when confronted by the decision to withhold or withdraw nutrition or hydration.

The secular society established a standard of moral conduct by governing itself through a representative form of government created by a voluntary joinder of different communities. Each community is bound by a common interest of economics, attitudes, stan-
A Moral Dilemma

Standards of conduct, practices and systems of beliefs for themselves or in relationships with other members of the community to which all or most subscribe. Each community or combination of communities establishes standards of moral conduct for members of that society of communities. The society created by combinations of communities is only a compromise of the various common interests of those several communities.

The moral standard which prevails in a particular community is imposed by that community upon its members. The community may be narrow or broad and is not necessarily limited to a geographic area, although it may be geographic in scope. The broader voluntary association of individuals can best be described as a society of various communities who do not share a common view of that which is good but who in fact pursue important goals together. Society, therefore, must reach some kind of an accommodation to resolve moral disputes among individuals who do not share a common moral vision of principles of right and wrong conduct. Moral actions include what acts, conduct, or decisions are acceptable to the community. A moral standard requires that similar situations be resolved substantially alike.

An analysis of the decision making process must begin with the determination of who should be the decision-maker, and what interests are involved absent a competent person or a compelling state interest. The cases seem to infer a variety of entities with an interest in the decision-making process. These interested entities include the patient, individually or through substituted judgment, the family as a consequence of emotional and financial involvement, the treating physician, the nursing care provider, and the entity providing housing such as a retirement home, nursing home, convalescent center, extended care facility, or hospital. Theologians and philosophers have an interest. The public at large through its legislative, executive or judicial branches of government has an interest.

The legislative and executive branches of our tripartite form of government set the standard, enact the law and establish public policy which is acceptable to the majority of the members of our society. The judicial process is not the battle ground for establishing public policy. Courts were created to resolve justiciable controversies. The inability of persons to resolve moral disputes does not create justiciable issues. The judicial process is convoluted when judges use a fiction to create a justiciable issue to resolve a moral problem through litigation. This is an attempted solution to a moral problem without any expression of a moral standard from an orderly society.
The Missouri Supreme Court in 1988 in *Cruzan v. Harmon* reviewed the situation of a thirty-one year old single woman lying in a hospital in a persistent vegetative state as a consequence of a single car accident. Her parents and co-guardians requested employees of the hospital to terminate artificial nutrition and hydration for the woman. The medical professionals refused to carry out their request without authority from a court, even though the ethical standards promulgated by the American Medical Association provide that nutrition and hydration is life prolonging medical treatment which may ethically be withdrawn.

The parents filed a declaratory judgment action, seeking a judicial sanction to their decision. Subsequent to a hearing, the trial court entered its order directing the medical professional of the hospital to “cause the request of the co-guardians to withdraw nutrition or hydration to be carried out.”

Judge Robertson, writing for a 4-3 majority in the Missouri Supreme Court, said “[a] single issue is presented: May a guardian order that all nutrition and hydration be withheld from an incompetent ward who is in a persistent vegetative state, who is neither dead . . . nor terminally ill? . . . We find that the trial court erroneously declared the law, we reverse.” The majority commented upon cases from sister states and expressed a duty to consider precedents from sister states that have grappled with the issue before them, but also to determine their strength. The precedents from sister states, to support the trial court, were found wanting by the Missouri Supreme Court. The court, at the conclusion of its opinion, said

There is another compelling reason to leave changes in policy in this area to the legislature. Representative bodies generally move much more deliberately than do courts; they are a bit slow and ponderous. Courts on the other hand are facile and eager to find and impose a solution. But the medico-legal challenge in this debate is not, as is so often said, to overcome the failure of the law to keep pace with medical technology. The challenge is to prevent dilemmas of medical decision-making from forcing upon us undesirable changes in the law. . . . When facing issues of life and death, society is best served when decisions are surefooted, not swift and ultimately uncertain.

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66. See *supra* note 8 for AMA ethics opinion on withdrawing nutrition and hydration.
67. *Cruzan* at 410. The trial court held that state laws which prohibited withholding and withdrawing of nutrition and hydration in all circumstances were unconstitutional, violating both federal and state rights of privacy. *Id.*
68. *Id.* at 410.
69. *Id.* at 426.
70. *Id.* at 426-27 (quoting Koop & Grant, The “Small Beginnings” of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing, 2 J.L.L.P. 586, 616 (1986)).
The United States Supreme Court, in a one line order on the final day of its 1988-1989 term, granted certiorari.\(^{71}\)

The Illinois Supreme Court, in November, 1989, in a four to two decision, filed an opinion in *In Re Estate of Longeway.*\(^{72}\) The appellant, daughter and guardian of the estate and person of Dorothy M. Longeway, petitioned the trial court to enter an order permitting her to withdraw artificially administered nutrition and hydration sustaining her mother.\(^{73}\) The appellee, Community Convalescent Center, the nursing facility where Mrs. Longeway resided, intervened and filed a motion to dismiss. The trial court granted the motion to dismiss. The Illinois Supreme Court reversed and remanded with directions to the trial court.

The issue in the case was whether the guardian of an incompetent, seriously ill patient may exercise a right to refuse artificially administered nutrition and hydration on behalf of the ward, and if so, how this right may be exercised.\(^{74}\) The court said, "[t]he courts which have grappled with the issue . . . have found themselves thrust into a realm where law, medicine and religion intersect. . . . The role of the judiciary in this area is an uncertain one."\(^{75}\) The court declined to address the issue in terms of the federal constitutional privacy guarantees or the privacy provisions of the Illinois State Constitution.\(^{76}\)

The issue was decided on the premise that the right to refuse artificially administered nutrition and hydration is based on the common law and the Illinois Probate Act.\(^{77}\) The Supreme Court reversed and remanded with directions to the trial court for a hearing on the "substituted judgment" theory, stating "the guardian is not instituting a legal proceeding for suit on behalf of a ward, but is merely petitioning the court for authority to perform an act which is within the implied authority granted by the Illinois Probate Act."\(^{78}\)

The Illinois Supreme Court set a five part test, allowing an incompetent patient to refuse, through a surrogate, artificially adminis-

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73. Mrs. Longeway had suffered a series of strokes and other illnesses over a period of thirteen years which had rendered her unconscious. She has lost all personality, memory, purposeful action, social interaction, thought and emotion. Her prognosis is very poor. "[A]lthough she is not medically brain dead the neurological damage is so extensive that she will never regain consciousness." *Id.* at 36, 549 N.E.2d at 293.
76. *Id.* at 44, 549 N.E.2d at 297. See *Illinois Statutes* ch. 110 ½ paras. 1-1 - 30-3 (1987).
istered nutrition and hydration. The test is as follows:
(1) the patient must be terminally ill, as statutorily defined in the Living Will Act as "an incurable and irreversible condition which is such that death is imminent and the application of death delaying procedures serves only to prolong the dying process."; (2) the patient must be diagnosed as irreversibly comatose or in a persistently vegetative state; (3) the diagnosis by the patient's attending physician must be safeguarded with at least two other consulting physicians concurring in the diagnosis; (4) the trial court must balance the eligible patient's right to discontinue externally supplied nutrition and hydration against any of the four countervailing interests the state may have in continuing it, being:
   (i) preservation of life; (ii) the protection of the interests of innocent third parties; (iii) the prevention of suicide; and (iv) maintaining the ethical integrity of the medical profession; and
(5) the presumption existing in the preservation of life, the proof required in determining the patient's intent should be upon clear and convincing evidence.

The court said the "substituted judgment" theory has been implicitly adopted in Illinois by the Powers of Attorney for Health Care Law, and then invited the legislature to address the problem.

Because we believe the right to refuse artificial sustenance is premised on common law and not necessarily constitutionally based, the legislature is free to streamline, tailor, or overrule the procedures outlined in this opinion to the extent that no constitutional doctrine is abrogated. The legislature is the appropriate forum for the ultimate resolution of the questions surrounding the right to die.

Two dissenting opinions criticized the majority for the assumptions made by the majority to support its opinion. The criticism addressed the lack of informed consent and the lack of a clear expression from the incompetent patient. In his strongly worded dissent, Justice Clark suggested that the majority's venture into legislation is

79. ILL. REV. STAT. ch. 110 1/2 paras. 701-10 (1987).
80. Id. at para. 702-(h).
81. The court quoted from Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 421 n.4, 497 N.E.2d 626, 628 n.4(1986), defining a persistent vegetative state as "a condition in which the patient:
(a) shows no evidence of verbal or non-verbal communication;
(b) demonstrates no purposeful movement or motor ability;
(c) is unable to interact purposely with stimulation provided by his environment;
(d) is unable to provide for his own basic needs;
(e) demonstrates all of the above for longer than three months."
Longeway at 47, 549 N.E.2d at 298.
82. Longeway at 47-51, 549 N.E.2d at 298-300.
83. ILL. REV. STAT. ch. 110 1/2 paras. 804-1 - 804-12 (1987).
84. Longeway at 53, 549 N.E.2d at 301.
dangerous and unnecessary. The legislature is the body to express public policy. Justice Clark analyzed the decisions cited by the majority and, by his analysis, the long list of cases decided in sister states upon which the majority relied, was whittled down to two cases, each of which reached a different conclusion in vehement four to three decisions. The majority and the two dissenting opinions all consistently stated that the legislature is in a better position than the courts to resolve the issues presented in a decision to withhold or withdraw nutrition and hydration.

**Conclusion**

An orderly democratic society functions through consensus and deliberation. The process of consensus and deliberation occurs through its legislative branch of government when it enacts legislation to establish standards of conduct. The acts of the legislative branch initiate the development of the morality of the society in which the decision is made. The function of the court is to determine if the legislature has exceeded the limits of the authority granted to the legislature by the society which it governs.

While the legislature is an expression of the will of the people whom it governs, and the executive must adhere and support and compel performance under the law, it is the judiciary to whom an appeal is made to resolve issues which others are unwilling or unable to resolve. Frequently the persons or entities who have the responsibility for making the decision abdicate their responsibility or are unable to reach agreement in discharging that responsibility.

When a judge decides whether or not to permit a person, acting under the judicial fiction of substituted judgment, to determine whether to withhold or withdraw nutrition and hydration, the decision includes granting that person the individual right to make a moral judgment of when life ceases to exist or the quality of life is worth living. The decision by the judge is the first individual moral decision without any expression of the standard of moral conduct from the community or society.

Life in this world is finite. There are times when we lack the certainty of continued existence. We shore up that uncertainty with pronouncements that lack a moral foundation. Society expects that these pronouncements, judicial decisions accepted by society as final after all appeals are exhausted, will treat similar cases in similar ways. The highest courts of the several states which have considered and decided the propriety of withholding or withdrawing nutrition and hydration are not in agreement as to the process or procedure to be used. This should not be surprising considering the lack of a clear expressed standard of moral conduct from the community or soci-
ety. The judiciary does not represent any segment of society. It is only when the legislative and executive branches of our government act that the judiciary can make a determination, and resolve the ambiguity of the competing interests.