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# Euthanasia: The Physician's Liability, 10 J. Marshall J. Prac. & Proc. 148 (1976)

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# EUTHANASIA: THE PHYSICIAN'S LIABILITY

## INTRODUCTION

The term "euthanasia" is derived from a combination of two Greek words: *eu*, which means happy or normal, and *thanatos*, which means death. Its equivalent colloquialism is "mercy-killing." However, any attempt to define euthanasia in terms of word origins merely scratches the surface. Today the word is used to describe a myriad of situations which differ widely in nature and legal consequence. These differing situations often overlap, and the distinctions between the various "forms" of euthanasia frequently become blurred.

Generally, euthanasia involves the killing, by acts or omissions, of a person suffering from a terminal illness or injury.[1] From this general statement, euthanasia is often "subdivided" into various "forms" based on the nature of the act or omission involved, and the presence or absence of the victim's consent.[2] Thus, *active* euthanasia necessitates an affirmative act which results in the patient's death[3] while *passive* euthanasia occurs when the physician (or another) takes no affirmative measures to save or prolong the patient's life.[4] *Voluntary* euthanasia involves some form of consent by the patient or another acting on the patient's behalf to the act or non-act resulting in death[5] while *involuntary* euthanasia occurs without

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1. *See* BLACK'S LAW DICTIONARY 654 (4th ed. 1968):
The act or practice of painlessly putting to death persons suffering from incurable and distressing disease.
Euthanasia may be performed in a number of ways; the physician may affirmatively inject air or a lethal drug into the patient's blood stream, a life-saving operation may not be performed upon the patient, or a respirator or other life support mechanism sustaining the patient may be disconnected.

2. *See Symposium—Euthanasia*, 27 BAYLOR L. REV. 1 (1975); Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723 (1973); Note, *Euthanasia—The Individual's Right to Freedom of Choice*, 5 SUFFOLK L. REV. 190 (1970).

3. What constitutes an "affirmative act"? While most authorities will agree that a physician who injects a lethal drug into the patient's blood stream acts affirmatively, there is considerable disagreement whether the physician "acts" by unplugging the patient's respirator. *See* Cannon, *The Right to Die*, 7 HOUSTON L. REV. 654 (1970) [hereinafter cited as Cannon]; Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967) [hereinafter cited as Fletcher].

4. *But see* Vodiga, *Euthanasia and the Right to Die—Moral, Ethical and Legal Perspectives*, 51 CHI.-KENT L. REV. 1 (1974). Mr. Vodiga distinguishes between euthanasia and "letting death occur." Thus, the physician who would fail to employ treatment designed to prolong the patient's life, whereafter the patient died of his affliction, would not have committed euthanasia at all. Most writers today would identify this situation as a form of passive euthanasia. *See* Cannon and Fletcher note 3 *supra*.

5. Should third party consent be considered "voluntary," or should

the consent of the patient or another.[6] These seemingly clear-cut distinctions become blurred when they appear in combined form; for example, the patient may "consent" not to be given a life-saving operation (*voluntary-passive*), or he may be injected with a fatal drug without his consent (*involuntary-active*). Between these two extremes exist other combinations, all of which add to the complexity of the situation.[7]

Also to be considered is the use or non-use of extraordinary treatment to prolong the patient's life. Extraordinary treatment is defined as medicine, operations, or other treatment which cannot be obtained and employed without considerable expense, pain or other inconvenience, and which provide no reasonable hope of lasting benefit to the patient.[8] A physician who accepts and treats a patient has a duty to use ordinary means to preserve his patient's life, but there is no corollary duty to employ extraordinary means.[9]

The physician plays a major role in the euthanasia decision.[10] He diagnoses the patient's affliction, evaluates the patient's condition and arrives at a professional opinion as to the seriousness of that condition. He prescribes the necessary treatment to be given the patient and acts as a consultant and advisor to the patient and those intimately involved with him. Furthermore, the physician is often directly involved in the act or non-act which results in the terminal patient's death.

For his role in the euthanasia decision, the physician may be subject to both criminal and civil liability. An important consideration in assessing the physician's liability in this area involves the standard of care the physician owes his patient. This standard requires the physician to possess the knowledge and skill possessed by an average physician in the community, and to exercise reasonable care in the use of that skill.[11] In Illinois, the courts have said:

> 'The duty which the defendant, as a physician . . . owed to the patient, was to bring to the case . . . that degree of knowledge,

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this term apply only to the patient's consent? *See* text accompanying note 140 *infra*.

6. *See* note 2 *supra*.

7. Other situations could involve *involuntary-passive* euthanasia, where the patient's life support systems are ended without his consent; or *voluntary-active*, where the patient consents to affirmative acts which end his life.

8. *See* Foreman, *The Physician's Criminal Liability for the Practice of Euthanasia*, 27 BAYLOR L. REV. 54 (1975) [hereinafter cited as Foreman].

9. *Id.*

10. *See* Teel, *The Physician's Dilemma*, 27 BAYLOR L. REV. 6 (1975); Williamson, *Should the Patient Be Kept Alive?* 44 MED. ECON. 63 (1967).

11. PROSSER, LAW OF TORTS § 32 (4th ed. 1971).

> skill and care which a good physician . . . would bring to a similar case under like circumstances.'[12]

The court went on to explain this standard:

> 'While this rule, on the one hand, does not exact the highest degree of skill and proficiency attainable in the profession, it does not, on the other hand, contemplate merely average merit.'[13]

A recurring consideration is whether this standard of care is being met as the physician interacts with his terminal patient.

This article will examine the physician's role in the euthanasia decision in the context of the liability to which the physician is exposed because of this role. What defenses are available to the physician? Does the particular "form" of euthanasia involved make a difference in assessing his liability? As a practical matter, what are the chances that a physician will be held liable in a euthanasia situation? Answers to these questions will be suggested through an analysis of the present law in this area. Proposed statutes to liberalize the law on euthanasia, together with the policy reasons behind such proposed legislation, and the counter-arguments thereto, will be examined.

## Criminal Liability

In Illinois, the statute defining murder states:

> A person who kills an individual without lawful justification commits murder if, in performing the acts which cause the death: (1) he either intends to kill . . . that individual . . . or he knows that such acts create a strong probability of death . . . to that person . . . .[14]

At common law, murder was considered to be the act of killing a person with malice aforethought.[15] "Malice" was not used in the ordinary sense as meaning hatred or ill-will, but rather in the legal sense of the *intent* to kill or the *knowledge* that the act performed would probably cause death.[16] *North Carolina v. Tilley*[17] offers the following succinct statement of the principle:

> Malice is not only hatred, ill-will, or spite, as it is ordinarily understood, but it also means that condition of mind which prompts a person to take the life of another intentionally without just cause, excuse, or justification.[18]

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12. Borowski v. Von Solbrig, 14 Ill. App. 3d 672, 678, 303 N.E.2d 146, 150 (1973), *citing* Holtzman v. Hoy, 118 Ill. 534, 536, 8 N.E. 832 (1886).
13. *Id.*
14. Ill. Rev. Stat. ch. 38, § 9-1 (Supp. 1976).
15. Perkins, Criminal Law 27 (2d ed. 1969) [hereinafter cited as Perkins].
16. *Id.*
17. 18 N.C. App. 300, 196 S.E.2d 816 (1973).
18. *Id.* at 302, 196 S.E.2d at 818.

When it has been established that the defendant had the requisite mental state and performed the act without lawful justification,[19] the legal elements for murder have been satisfied. That which induced the defendant to act is immaterial; thus, the fact that the defendant may have acted out of sympathy toward his victim is of no legal consequence as regards his criminal liability. The cases in Illinois and elsewhere agree that *motive* is not an essential element of the crime.[20]

From the above analysis, it is clear that a physician who performs euthanasia upon a patient is, under strict legal terminology, liable for murder. He intends by his acts to end the life of the patient, and any feeling of sympathy he may exhibit in performing the acts is not a material factor in determining his criminal liability. Equally unavailing as a legal defense is the physician's belief that he is *morally* justified in his actions since "he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief."[21]

### *Consent*

In *voluntary* euthanasia situations, the patient's consent to the act of euthanasia is of no legal assistance to the physician seeking to escape criminal liability for his act. The law is settled that the victim's consent is no defense to the crime of murder.[22] At this point, it is useful to distinguish between *active* and *passive* euthanasia.[23] The settled law which states that consent is no defense to murder may be readily applied to *active* euthanasia as, for example, when the physician injects his patient with a lethal drug. However, the law is not as readily applicable to certain forms of *passive* euthanasia. Acts of omission by a physician resulting in the death of his patient render the physician criminally liable only when the physician is under a legal duty to act.[24] Once the physician-patient relationship commences, the physician is subject to a legal duty to continue treatment, barring an agreement limiting such treatment, as long

19. A homicide committed in self-defense is justifiable. *See* PERKINS, *supra* note 15.

20. People v. Mangano, 375 Ill. 72, 30 N.E.2d 428 (1940).

21. People v. Conley, 64 Cal. 2d 310, 322, 411 P.2d 911, 918, 49 Cal. Rptr. 815, 822 (1966).

22. *See, e.g.*, Turner v. State, 119 Tenn. 663, 108 S.W. 1139 (1908), where the defendant shot and killed his girl friend after she had pleaded with him for several months to kill her. Defendant's conviction of murder was upheld. *See also* People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920), where the victim's husband had placed a glass of poison within the reach of his invalid wife, who later picked it up and drank it, fully aware of its contents. *Held*: It is murder to aid and abet a suicide.

23. *See* text accompanying notes 3-4 *supra*.

24. *See* Foreman, note 8 *supra*.

as the case requires attention; the physician must exercise reasonable skill and care in determining whether his care can be properly and safely terminated.[25] Thus, during the treatment period the physician is under a legal duty to act in the patient's interests, and his failure to so act may subject him to criminal liability.

In some jurisdictions, a patient may refuse to consent to the initiation of life-saving treatment, in which case the physician will not be held criminally liable for his failure to act. *In re Estate of Brook*[26] is a good example. There, the patient, a member of the Jehovah's Witnesses, refused blood transfusions necessary to save her life. The Illinois Supreme Court held that the patient's refusal would be honored:

> 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 action cannot be constitutionally countenanced.[27]

By refusing life-saving treatment, the patient has essentially absolved the physician of his legal duty to act, and it has been shown that absent this duty, no criminal liability will attend the physician's omission.[28]

### *What Is Death and When Does It Occur?*

An essential element of murder is that the criminal agency of the defendant cause the victim's death. A person cannot be convicted of the murder of another who is already dead at the time of the act.[29] Thus twin problems arise: what is death, and when does it occur?

Black's Law Dictionary defines death as:

> The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation . . . .[30]

Most earlier cases followed this definition verbatim,[31] and some specifically rejected the recognition of "brain death" as a viable legal concept, holding that "a body is not dead so long as there is a heart beat . . . . This is so though the brain may have quit

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25. *See* text accompanying notes 11-13 *supra.*
26. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).
27. *Id.* at 373, 205 N.E.2d at 442.
28. *See* text accompanying note 24 *supra.*
29. 1 WHARTON'S CRIMINAL LAW & PROCEDURE § 189, at 435 (And. ed. 1957).
30. BLACK'S LAW DICTIONARY 488 (4th ed. 1968).
31. *See, e.g.*, Schmitt v. Pierce, 344 S.W.2d 120 (1961); Smith v. Smith, 229 Ark. 579, 317 S.W.2d 275 (1958).

functioning."[32] However, in recent years a number of state legislatures have heeded the arguments of brain death proponents[33] and have passed statutes legally recognizing this form of death for all or limited purposes. In essence, these statutes provide two definitions of death: the absence of spontaneous respiratory and cardiac functioning (similar to the common law definition of death), and in the alternative, the absence of spontaneous brain functioning.[34] Representative of the states which have enacted such legislation, Kansas[35] and Maryland[36] provide for a broad application of the brain death definition which covers most instances where the occurrence of death is at issue. Virginia[37] adopts the definition in The Uniform Anatomical Gift Act, but explicitly indicates that it is applicable elsewhere. Many states, on the other hand, including Illinois, confine the meaning of brain death to those situations arising under The Uniform Anatomical Gift Act only.[38]

The importance of these statutes to the physician in respect to the euthanasia situation is significant. If the patient's EEG is no longer active, indicating a cessation of brain functioning, the patient may be pronounced legally dead, even though his heart is still beating. In this situation, the physician who unplugs the patient's respirator (which may be allowing his heart and lungs to continue functioning) and thereby hastens death, will escape criminal liability for his actions.

### *Practical Aspects of Criminal Liability*

Aside from considerations of consent and legal death, the probability of a physician being held criminally liable for an act of euthanasia is of concern. Although it appears that euthanasia, especially in passive form, is frequently practiced,[39] only once has a conviction of murder resulted therefrom.[40] In other

32. Gray v. Sawyer, 247 S.W.2d 496, 497 (1952).

33. *See* Hamlin, *Life or Death by EEG*, 190 J.A.M.A. 112 (1964); *Fletcher, supra* note 3.

34. *See also* Friloux, *Death, When Does It Occur?*, 27 BAYLOR L. REV. 10 (1975); Biorck, *When Is Death?*, 18 WIS. L. REV. 494 (1968).

35. KAN. STAT. ANN. art. 2, § 77-202 (Supp. 1975).

36. MD. CODE ANN. art. 43, § 54F (Supp. 1975).

37. VA. CODE ANN. ch. 19.2, § 32-364.3:1 (Supp. 1976).

38. ILL. REV. STAT. ch. 3, § 552 (Supp. 1976).

39. Levisohn, *Voluntary Mercy Deaths*, 8 J. FOR. MED. 57 (1961). Mr. Levisohn conducted a survey of 250 Chicago area internists and surgeons; 156 replied and 61% of those who answered felt that "physicians do actually practice euthanasia in instances of incurable adult sufferers." *Id.* at 68.

40. John Noxon was convicted of first degree murder for killing his six-month old mongoloid son. His death sentence was later commuted to six years imprisonment, and he was paroled after serving four years. Commonwealth v. Noxon, 319 Mass. 495, 66 N.E.2d 814 (1946). For a discussion of this case see *Survey—Euthanasia: Criminal, Tort, Constitu-*

known cases involving "mercy-killers," there have been three convictions of a lesser crime,[41] seven acquittals and one failure to indict.[42]

These statistics tend to show that although a physician or other "mercy-killer" may be legally liable for murder, his chances of being convicted are slight. A number of reasons account for this result. First, if the case is being tried by a jury, it is unlikely that a conviction will result, or if there is a conviction, it is unlikely that it will be for murder.[43] From the example afforded by the majority of euthanasia cases,[44] it appears that juries are reluctant to return a verdict of guilty against a defendant who kills out of kindness or sympathy toward his victim. It appears simply contrary to human nature to punish the "mercy-killer" to the fullest extent of the law.[45] One "tactic" of juries searching for ways to be lenient with the "mercy-killer" is to find the defendant temporarily insane at the time of the death.[46] Second, there are problems of causation. Because the act of euthanasia is most often performed outside the view of any witnesses, it is difficult to prove the physician's criminal agency as the cause of the death.[47] In situations where the physician disconnects the patient's life support treatment, there is the further argument that it is not the physician's act but rather the patient's affliction which actually causes death.[48] Third, due to the foregoing reasons, and also because public senti-

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*tional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1213-14 (1973) [hereinafter cited as *Survey*].

41. *See* Repouille v. U.S., 165 F.2d 152 (2d Cir. 1947), where a father used chloroform to kill his 13 year old son, who had been physically and mentally deformed since birth. The jury, upon an indictment for first-degree murder, returned a verdict of second-degree manslaughter, and father received a suspended sentence of five to ten years imprisonment.

42. For a discussion of these cases see *Survey*, *supra* note 40. *See also* Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178, 184-86 (1966) [hereinafter cited as Williams] for the recorded trial transcript of a case which resulted in the acquittal of a man charged with the murder of his invalid wife. People v. Werner, Crim. No. 58-3636 (Cook Co. Ill. 1959). The trial judge stated:

> Courts don't usually condone mercy-killings, but . . . I think a jury would not be inclined to return a verdict of guilty . . . . This is a time in one's life when a good reputation and decency pay off. I can't find it in my heart to find you guilty.

43. *See, e.g.*, Repouille v. U.S., 165 F.2d 152 (2d Cir. 1947) and Williams, *supra* note 42.

44. *See* text accompanying notes 40-42 *supra*.

45. Thus, while motive is technically neither an element of nor a defense to murder, *see* text accompanying note 20 *supra*, it emerges as a strong practical consideration in any attempt to convict the "mercy-killer."

46. *See* Note, *Euthanasia—The Individual's Right to Freedom of Choice*, 5 SUFFOLK L. REV. 190, 201 (1970). *See also* State v. Zygmaniak, No. 1197-72 (Super. Ct. Monmouth Co., N.J., 1973).

47. *See* Williams, *supra* note 42.

48. *See* Note, *Unauthorized Rendition of Life-Saving Treatment*, 53 CALIF. L. REV. 860 (1965).

ment is usually on the side of the "mercy-killer," prosecutors recognize the slight chances for convictions and rarely initiate prosecution.[49]

## THE QUINLAN CASE

A recent development in the law of euthanasia is the case *In re Quinlan*.[50] In mid-April of 1975, Karen Quinlan lapsed into a coma during which she stopped breathing for two fifteen minute periods. She was taken to a hospital and put on a respirator to aid her breathing.[51] Subsequent tests conducted on Miss Quinlan determined that she did have some brain stem function and other reaction to external stimuli,[52] but that she was existing in a "chronic persistent vegetative state."[53] Nearly one year later the matter was brought before the New Jersey Supreme Court, after Karen's father had unsuccessfully petitioned a lower court for authorization to terminate the respirator treatment.[54] The supreme court reviewed Miss Quinlan's condition and found that: (1) severe brain damage had occurred, leaving her in a chronic and persistent vegetative state; (2) medical science could afford no reasonable expectation of a cure for her condition; (3) the respirator treatment merely prevented a rapid deterioration of her condition; and (4) if the respirator were removed, she would die in a short time.[55]

Even under these circumstances, Miss Quinlan's attending physician refused to disconnect the respirator, stating that existing medical standards would not permit discontinuance of any treatment necessary to sustain a patient's life.[56] The lower court upheld this contention, and Mr. Quinlan appealed to the New Jersey Supreme Court, seeking to be appointed legal guardian of his daughter with judicial authorization to disconnect her respirator.[57]

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49. *See* note 45 *supra*.
50. 70 N.J. 10, 355 A.2d 647 (1976).
51. Miss Quinlan's physician diagnosed the breathing disorder as anoxia (lack of oxygen in the bloodstream), a disorder caused by a neurological abnormality which severely limited Karen's respiratory functions. The respirator was necessary, in the physician's view, to assist the respiratory functions and help ward off infection in other parts of Karen's system.
52. From this data, physicians agreed that Karen was not "brain dead."
53. 70 N.J. 10, 25, 355 A.2d 647, 654 (1976).
54. *In re* Quinlan, 137 N.J. Super. 227, 348 A.2d 801 (1975).
55. The findings were made after the court had received testimony from Karen's attending physician and other experts who had studied her case history.
56. *See* text accompanying note 11 *supra*. *See also* text accompanying note 85 *infra* for a further discussion of this aspect of the case.
57. 70 N.J. 10, 22, 355 A.2d 647, 653 (1976).

### *The Court's Decision and Reasoning*

The New Jersey Supreme Court was faced with numerous issues, several of which are outside the scope of this discussion.[58] The critical issue before the court was whether Karen's father or physician could terminate her life-support mechanisms without being subject to civil or criminal liability. Deciding this question in the affirmative, the court appointed Mr. Quinlan legal guardian of his daughter's person and property,[59] and authorized him to disconnect the respirator if (1) Karen's family concurred in the decision; (2) her attending physician concluded that there was no reasonable expectation of her recovery; and (3) a hospital "Ethics Committee"[60] was consulted and agreed with the physician's prognosis.

The court reasoned that Karen could, in the free exercise of her right of privacy,[61] effectively request that her respirator be disconnected. Furthermore, since Karen was incompetent,[62] the court concluded that her right of privacy could be asserted by her father as legal guardian.[63] The state's interest in the preservation of human life would not bar the assertion of Karen's right of privacy because of the severity of Karen's condition:

> We think that the State's interest [in the preservation of life] weakens and the individual's right of privacy grows as the degree of bodily invasion increases and the prognosis dims.[64]

To determine the validity of the physician's contention that the removal of the respirator would offend traditional medical standards, the court reviewed the applicability of those standards to terminal patients. It is noted that physicians as a matter of policy do not initiate respiratory treatment on hopelessly afflicted patients who have stopped breathing thus refusing to pro-

58. The court held, *inter alia*, that Mr. Quinlan had a sufficient adverse interest in the controversy to have standing. The court also held that free exercise of religion was not a basis for disconnecting the respirator, since acts pursuant to religious beliefs are not wholly immune from government restraint. Also, Karen's condition did not constitute "cruel and unusual punishment" since that term applies only to criminal sanctions. Although Karen's condition could be termed "cruel and unusual" the court held that it was not "punishment" as the word is legally understood. *Id.* at 34-38, 355 A.2d 647, 660-62.

59. There was some dispute as to whether guardianship should be bifurcated, and whether Mr. Quinlan appointed guardian of only the property of his daughter. The court rejected this argument. 70 N.J. 10, 53, 355 A.2d 647, 670-71 (1976).

60. 70 N.J. 10, 54, 355 A.2d 647, 671 (1976). The concept of an "Ethics Committee" is discussed at length in Teel, *The Physician's Dilemma*, 27 BAYLOR L. REV. 6 (1975). The committee would normally consist of physicians, attorneys, theologians, and hospital administrators.

61. The right was first discussed in 1890 in an article co-authored by Louis D. Brandeis and Samuel D. Warren, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890) [hereinafter cited as Brandeis].

62. *See* text accompanying note 83 *infra*.

63. 70 N.J. 10, 28, 355 A.2d 647, 664 (1976).

64. *Id.*

long the life of a terminal patient where such prolongation would serve no humane benefit.[65] Such a practice was found to be in accordance with medical standards and could be analogized to the discontinuance of respiratory treatment as well. The court was careful to point out that the respirator was extraordinary means of treatment,[66] and that it would not improve or cure Karen's condition; under these circumstances it would not offend medical standards to terminate such treatment.

The *Quinlan* case is unique in that it represents the first instance in which a court has actually approved the discontinuance of life support treatment. Heretofore, judicial involvement in euthanasia situations had been limited to reviewing the propriety of acts already performed[67] and authorizing (or failing to authorize) the initiation of life-saving treatment. Particularly significant aspects of the ruling include the court's discussion of the right of privacy, its treatment of existing medical standards, and the effect of the ruling on the physician's civil and criminal liability.

### *The Right of Privacy and Euthanasia*

In 1914, Justice Cardozo, then a member of the New York Court of Appeals, outlined the patient's right to self-determination over his body. In *Schloendorff v. Society of New York Hospitals*,[68] Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."[69] It is this concept of self-determination that the New Jersey Supreme Court sought to invoke in the *Quinlan* case under the right of privacy rationale.

Though not specifically enumerated in the Bill of Rights, numerous authorities[70] and courts have determined that a right of privacy does indeed exist. *Griswold v. Connecticut*[71] found that the right of privacy exists as a corollary to various specifically enumerated rights. *Stanley v. Georgia*[72] and *Olmstead v. United States*,[73] both recognized "the right to be left alone—the

65. Thus, if a terminal cancer patient stopped breathing, the physician responsible for the patient would not generally initiate cardio-vascular and respiratory treatment, if such treatment would merely revive the patient for a few days.

66. *See* text accompanying notes 8-9 *supra*.

67. *See* text accompanying notes 26-29 *supra*.

68. 211 N.Y. 125, 105 N.E. 92 (1914).

69. *Id.* at 126, 105 N.E. at 93.

70. *See* Brandeis, *supra* note 61. *See also* Doss, on *Morals, Privacy, and the Constitution*, 25 MIAMI L. REV. 395 (1975); Ervin, *Privacy and the Constitution*, 50 N.C.L. REV. 1016 (1972).

71. 381 U.S. 479 (1965).

72. 394 U.S. 557 (1969).

73. 277 U.S. 438 (1928).

most comprehensive of rights and the most valued by civilized men."[74] In *Eisenstadt v. Baird*,[75] the Supreme Court stated:

> If the right of privacy means anything, it is the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person . . . .[76]

Most recently, the decisions of *Roe v. Wade*[77] and *Doe v. Bolton*[78] applied the right of privacy rationale to allow a woman to have an abortion under certain circumstances.[79]

The New Jersey Supreme Court in *Quinlan* determined that under particular circumstances, *i.e.*, in the face of a terminal affliction which offers no hope of reversal, an individual possesses, in effect, a right to die. Such an individual may, in the exercise of his right of privacy, request that life-support treatment be discontinued. While never specifically referring to the right to die in its opinion, the concept is implicit in much of the court's reasoning. For example, the court states:

> We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval . . . and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death.[80]

This aspect of the court's holding is founded on sound precedent,[81] and appears to be logically based on the right of privacy reasoning. However, since Karen was incompetent the court was required to carry its holding one step beyond the individual's exercise of his right of privacy. The court thus permitted Karen's father as legal guardian to decide for her whether to continue the respirator treatment.[82] In doing so, the court extended the right of privacy to new legal limits—limits which may be too expansive. By its very nature, the right of privacy belongs to the individual. If persons other than the individual are allowed to assert this right, the term "privacy" must necessarily take on broad, heretofore unarticulated, dimensions.

The most rational explanation for the *Quinlan* decision is that the court was striving to achieve what it thought were the most humane results. It cites no authority to support its

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74. *Id.* at 478.
75. 405 U.S. 438 (1972).
76. *Id.* at 453.
77. 410 U.S. 113 (1973).
78. 410 U.S. 179 (1973).
79. It appears that the *Quinlan* court is following a recent trend started by the cases cited at notes 68-78 *supra*, to further develop and define the right of privacy.
80. 70 N.J. 10, 39, 355 A.2d 647, 663 (1976).
81. *See* text accompanying notes 70-79 *supra*. *See also* Delgado, *Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ L. REV. 474 (1975) [hereinafter cited as Delgado].
82. 70 N.J. 10, 42, 355 A.2d 647, 664 (1976).

decision to allow Mr. Quinlan to assert his daughter's right of privacy. Rather, in explaining its decision, the court points out that its refusal to delegate Karen's right of privacy to her father would essentially destroy the right altogether; this result, the court feels, is untenable.[83]

*Existing Medical Standards*

Karen's physician refused to disconnect her respirator because he felt such action would be contrary to existing medical standards of care, which forbade the discontinuance of treatment necessary to preserve the life of a patient, regardless of that patient's condition.[84] In reevaluating these standards, the *Quinlan* court felt that the standards should no longer apply to terminal patients who have no hope of recovering.

This appears to be a sound conclusion. The standard of care to which physicians are held directs them to possess the skill of an average physician in the community and exercise responsible care in using that skill to treat their patients.[85] The critical issue, in the context of euthanasia, lies in determining the exact parameters of the words "treat their patients." Arguably, "treatment" may involve prolonging a patient's life regardless of how hopeless his condition, or caring for a patient by affording him a reasonable expectation of curing or improving his condition. The *Quinlan* court decided that the customary medical standard of treatment applied in the latter situation, but not the former. The court buttressed its conclusion by pointing out that it is common practice of physicians and hospitals not to initiate treatment upon terminal patients who have stopped breathing. Thus, the rationale that the *initiation* of treatment offers no medical benefit to the patient beyond sustaining his life for a short period of time, may also be applied to the *discontinuation* of such treatment.[86]

Thus, the *Quinlan* holding modifies medical standards, although only to a limited extent. The standard to which physicians are held still requires that reasonable care be exercised in treating a patient, but no longer requires (at least in New Jersey) the continuation of treatment for the sole purpose of prolonging the life of an irreversibly terminal patient.

*The Physician's Liability*

There is no doubt that *Quinlan* will have a profound effect on the interaction between physicians and their terminal

83. *Id.* at 41-42, 355 A.2d at 664.
84. *See* text accompanying note 56 *supra.*
85. *See* text accompanying note 11 *supra.*
86. *See* text accompanying note 65 *supra.*

patients. In recent years, the increase of malpractice suits has left physicians understandably reluctant to openly discontinue any treatment, even when the patient's condition is irreversibly terminal. The *Quinlan* court, responding to the immensely complicated issues involved in this area, outlined a procedure whereby the physician will not be subject to civil or criminal liability for terminating the extraordinary treatment of his patient.

*Civil Liability*

Consent by the patient to medical treatment has long been a defense for the physician faced with civil liability for rendering that treatment.[87] *Quinlan* extends this legal principle to cover the situation of a patient's consent to termination of life-support treatment. The holding goes further, however, to consider and validate a form of "multi-third party consent" involving concurrence by the patient's family, guardian, physician, and hospital "Ethics Committee." Thus through the "diffusion of professional responsibility,"[88] the physician would be protected from civil liability for discontinuing his terminal patient's extraordinary treatment.

The procedure outlined by the court should promote discussion of the issues presented by the proposed discontinuation of treatment, and should result in an informed decision by the parties involved. From the standpoint of the physician's liability, which is intricately tied to the euthanasia decision, the multi-third party consent concept has the practical effect of precluding lawsuits by those who would have standing to contest the termination of extraordinary treatment.

*Criminal Liability*

Consent by the patient or third persons is not a defense to criminal liability.[89] The *Quinlan* court found, however, other reasons to conclude that criminal liability would not exist under the circumstances surrounding the case before it. First, the patient's death following the disconnection of the respirator would be a *natural* result of her affliction rather than the criminal agency of the person who disconnected the respirator. Secondly, because the court based its decision upon the free exercise of the patient's right of privacy, it followed that no criminal law could validly punish the exercise of a constitutional right. More importantly, from the physician's standpoint, the constitu-

87. *See* text accompanying note 103 *infra.*

88. 70 N.J. 10, 49-50, 355 A.2d 647, 669 (1976). The court adopts this phraseology and the concept behind it from Dr. Teel's article, *supra* note 60.

89. *See* text accompanying note 22 *supra.*

tional protection is held to extend to anyone who effectuates the exercise of that right.[90] This follows logically from the reasoning in *Griswold v. Connecticut*.[91]

### *Perspective*

*Quinlan* is the first major decision which judicially approves the discontinuation of life-support treatment. It represents a significant relaxation of prior law in respect to a physician's civil and criminal liability for his role in the decision to terminate the treatment. However, there are a number of pivotal facts in the case which distinguish it from other euthanasia situations and may thus limit the impact of the case in related areas.

First, Karen was already on the respirator when the case was brought before the New Jersey Supreme Court. The relief sought thus involved the *discontinuation* of treatment, and is distinguishable from situations where a life-ending agent is sought to be introduced into the patient's body. This latter situation involves *active* euthanasia, and is still outside the permissible sphere of the law after *Quinlan*.[92]

Second, a respirator is an extraordinary form of treatment when it offers no reasonable hope of a cure for a terminal condition.[93] Had the respirator offered a hope of improvement for Karen, the *Quinlan* court would obviously not have approved its disconnection, because such treatment would be deemed ordinary and required by medical standards.[94] This raises questions about the other treatment which Karen was receiving. The court stated that Karen was getting "excellent" care by a team of four nurses. She was fed through a nasal-gastro tube and checked regularly for infection. After the respirator is disconnected, should this other care be continued? Consider the analogy between the respirator treatment and the feeding of a terminal patient. Both are procedures which prolong the life of a terminally ill patient without offering a hope of improvement. Both could be disconnected without actively inflicting deadly harm into the patient's body (as by a drug injection), resulting in the patient's death from natural causes. Recognizing these analogies, it is still logical to conclude that *Quinlan* does not

90. 70 N.J. 10, 51-52, 355 A.2d 647, 669-70 (1976).
91. 381 U.S. 479 (1965). In *Griswold*, the United States Supreme Court held that a married couple could not be criminally punished for purchasing or using contraceptives because such actions were within their right of privacy. Furthermore, the Court implied that the person who sold the contraceptives could not be subject to criminal sanctions because he was merely facilitating the couple's exercise of their constitutionally protected right of privacy. *Id.* at 485.
92. *See* text accompanying note 3 *supra*.
93. *See* text accompanying note 8 *supra*.
94. *See Symposium—Euthanasia*, 27 BAYLOR L. REV. 1 (1975).

stand for authorization to terminate the feeding of a hopeless patient. Had the *Quinlan* court intended that all treatment (including feeding) of Karen be stopped, it undoubtedly would have so stated. The *Quinlan* decision is, by its terms, limited to the termination of extraordinary forms of treatment. Feeding a patient is a natural, as opposed to an artificial treatment and therefore would be classified as an ordinary form of treatment which under medical standards is not to be discontinued, even after *Quinlan's* modification of the medical standards.[95]

Finally, the *Quinlan* court arguably extends the right of privacy rationale too far by allowing third parties to assert the right on behalf of incompetent patients. Whether future courts will agree that an individual's right of privacy can be exercised by other persons remains to be seen. A much stronger case for delegation can be made where the terminal patient has executed a "living will," an attested document in which the patient requests that he not be kept alive by extraordinary means.[96] Third parties who then discontinue such treatment would merely be effectuating the request of the patient pursuant to his right of privacy.

While *Quinlan* is undoubtedly a significant development in the law of euthanasia, its holding should affect only one distinct portion of that law. *Quinlan* represents one notable position above all others in that it allows persons other than the patient to make the decision to terminate the patient's life-support treatment. However, at the present time, it appears unlikely that the case could be interpreted to sanction all forms of euthanasia, including *active* euthanasia.[97]

The *Quinlan* decision is based on the constitutional issues raised under the right of privacy doctrine. However, the case did not thoroughly develop other traditional issues concerning physicians' civil liability in tort for acts of euthanasia. These other issues encompass the concept of consent in its various forms, such as third party and informed consent. The remainder of this article will concern itself with these issues.

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95. *See* Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723 (1973).

96. 70 N.J. 10, 355 A.2d 647 (1976).

97. "Active euthanasia" in the context of this statement, means affirmative acts other than merely unplugging a life support mechanism. *See* text accompanying note 3 *supra*. The reason that the *Quinlan* reasoning is not readily extendable to *active* euthanasia involves the nature of the conduct necessary to perform *active* euthanasia, *i.e.*, the affirmative introduction of a death-dealing agent into the life-streams of the patient. It is submitted that, on a purely emotional level, the unplugging of a respirator (itself an *extraordinary* means of treatment) is less objectionable to the sensibilities than the act of injecting a lethal drug into the patient's veins.

## CIVIL LIABILITY

A physician may be exposed to civil liability for wrongful death as a result of performing acts of euthanasia. In the examination of civil liability, the standard of care which the physician owes his patient becomes an important consideration.[98] To determine if the physician deviates from this standard in arriving at the euthanasia decision, and if so, to what extent, the reach of the patient's consent must be considered. The factors implicit in a valid, informed consent and related questions merit equal discussion.

### *Consent*

The physician has a duty to possess that skill and knowledge of an average physician in the community and to exercise reasonable care in using that skill in treating his patient.[99] However, even if he complies fully with this duty, the physician may yet be subject to civil liability. In *Mohr v. Williams*,[100] a physician was held civilly liable for performing a successful operation upon his patient's left ear to remove a diseased condition. The court held the physician liable for battery even though the operation had been performed with the requisite degree of skill and care since the patient had not consented to the operation and because no emergency endangering the patient's life was presented by the left ear's condition.[101]

This case illustrates the importance of the patient's consent to treatment administered to him by his physician. Thus, even when the physician satisfies his duty of care to the patient, liability for *intentional* acts to which the patient does not consent may still attach. Conversely, in most cases the patient's consent to the treatment will absolve the physician from civil liability.[102]

This concept of consent applies in the euthanasia situation as well, albeit with certain modifications. The role of patient consent in this area will first be considered in a negative sense, represented by those situations where the patient *refuses* medical treatment when it is necessary to save his life.[103] The courts have not fully agreed whether a physician must administer life-

98. *See* text accompanying notes 11-13 *supra*.
99. *Id.*
100. 95 Minn. 261, 104 N.W. 12 (1905).
101. However, because the operation was performed with reasonable skill and care and was a success, the court awarded the patient only minimal damages. *Id.*
102. "The consent of the person damaged will ordinarily avoid liability for the intentional interference with person or property." PROSSER, LAW OF TORTS § 18 (4th ed. 1971).
103. *See* text accompanying notes 27-29 *supra*.

saving treatment irrespective of his patient's refusal to consent thereto. *In re President & Directors of Georgetown College*[104] involved a patient who was suffering from a ruptured ulcer and had lost nearly two-thirds of her blood supply. The patient was a member of the Jehovah's Witnesses and because of her religious beliefs refused the blood transfusion necessary to save her life. The hospital sought a judicial order permitting the transfusion over the patient's refusal. In justifying its order compelling the transfusion, the court distinguished the case before it from the "question of whether the state should intervene to reweigh the relative values of life and death, after the individual has weighed them for himself and found life wanting. [The patient here] wanted to live."[105] The court discussed the legal position of the hospital and the doctors, and went on to cast doubt on the vitality of a patient's consent which would result in his or her death:

> It is not certain that [the patient] had any authority to put the hospital and its doctors to this impossible choice. . . . It is not clear just where a patient would derive her authority to command her doctor to treat her under limitations which would produce death. The patient's counsel suggests that this authority is part of constitutionally protected liberty. But neither the principle that life and liberty are inalienable rights, nor the principle of liberty of religion, provides an easy answer to the question whether the state can prevent martyrdom.[106]

However, the main factor which caused the court to issue its order compelling the transfusion was not the inability of the patient to refuse life-saving treatment. The court regarded the situation as an emergency in which there was no time to pause and disinterestedly consider competing interests. The situation required quick action, and in the final analysis the court decided to resolve the dilemma "on the side of life."[107]

*Georgetown* has not been followed unanimously; indeed, the authorities are almost evenly split on this matter.[108] Following *Georgetown* were *In re Long Island Jewish-Hillside Medical Center*[109] and *Collins v. Davis*.[110] In *Long Island Medical Center*, the court appointed a guardian who was permitted to consent to a necessary operation on a patient who had gangrene, in spite of

104. 331 F.2d 1000, *reh. denied*, 331 F.2d 1010, *cert. denied*, 377 U.S. 978 (1964).
105. *Id.* at 1009. Before issuing the order, Wright, J., had conferred with the patient, asking her whether she would accept the transfusion. The patient had indicated that, should the court order the transfusion, the matter would be "out of her hands." From this, it appears, the judge inferred that the patient "wanted to live."
106. *Id.*
107. *Id.* at 1010.
108. *See* text accompanying notes 27-29 *supra*.
109. 73 Misc. 2d 395, 342 N.Y.S.2d 356 (1973).
110. 44 Misc. 2d 622, 254 N.Y.S.2d 666 (1964).

the patient's protests against the operation. *Collins* involved a slightly different situation—the patient was unable to give his consent to a necessary operation because he was in a coma. However, the patient's wife having refused to consent to the operation for reasons the court found to be medically unsound, the court ordered the operation to proceed.

On the other hand, there have been a number of cases contrary to *Georgetown*, including *In re Brook's Estate*.[111] In *Erickson v. Dilgard*,[112] the court found that an adult patient had the right to refuse a blood transfusion "even if medical opinion was to the effect that patient's decision not to accept blood was just about the taking of patient's own life," and even though suicide was prohibited by New York's criminal statutes.[113] *In re Osborne*[114] and *Petition of Nemser*[115] are to the same effect.[116]

Arguably, a patient's refusal to consent to life-saving treatment is not really consent at all. The different considerations which exist in the area of "true consent," *i.e.*, when the patient *affirmatively* consents to measures which will end his life, are complex, and best arrived at by examining two factors: the doctrine of informed consent, and the concept of third party consent on behalf of the patient.

*Informed Consent*

It is settled in most instances that a patient's consent to treatment will be a defense to the physician who renders that treatment with reasonable care and skill.[117] However, in order to be valid, this consent must be *informed*.[118] Essentially, informed consent involves two elements: the patient must be made aware of the risks involved in the treatment, and he must assent thereto.[119] Disclosure of risks commonly known to the patient is unnecessary; only material risks must be disclosed.[120]

111. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).
112. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).
113. *Id.*
114. 294 A.2d 372 (D.C. Ct. of App. 1972).
115. 51 Misc. 2d 616, 273 N.Y.S.2d 624 (1966).
116. *See generally* Note, *Unauthorized Rendition of Life-Saving Treatment*, 53 CALIF. L. REV. 860 (1965).
117. *See* text accompanying note 102 *supra*.
118. *See* Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632 (1974) [hereinafter cited as *Informed Consent*]. Part of the rationale behind the informed consent concept involves the patient's right to determine when he will die. *See* Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).
119. *Id.*
120. *See, e.g.*, Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Getchell v. Mansfield, 260 Ore. 174, 489 P.2d 953 (1971). Obviously, what qualifies as a "material risk" differs from situation to situation.

The elements of informed consent are concisely stated in the leading modern case of *Natanson v. Kline*:[121]

> [T]he proper rule of law to determine whether a patient has given an intelligent consent to a proposed form of treatment by a physician . . . . compels disclosure by the physician in order to assure that an informed consent of the patient is obtained. The duty of the physician to disclose, however, is limited to those disclosures which a reasonable [physician] would make under the same or similar circumstances. . . . So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.[122]

Does this concept of informed consent have validity in the area of euthanasia? Note that the physician is held to a continuing duty to disclose all pertinent information to the patient. It can be argued that this duty also compels disclosure to the patient that, in the physician's professional opinion, the patient is suffering from a terminal affliction from which there is little or no hope of recovery. Whether a reasonable physician under the circumstances would make such a disclosure is open to some question. On the one hand, such disclosure might not be in the patient's "best therapeutic interests," causing him to suffer extreme depression and "give up on life."[123] Furthermore, the practical effect of such a disclosure by the physician may be to put the physician himself in a bad light, as if admitting that any further care would prove fruitless. Conversely, the situation of many terminal patients is such that impending death is obvious. In these cases, it may indeed be in the "best therapeutic interests" of the patient, especially psychologically, that the physician candidly disclose the patient's condition to him.[124]

Any solution to this dilemma must turn on the facts and circumstances of each particular case. Factors influencing the decision to disclose include the intensity of the patient's pain and suffering, whether because of this pain he is able to fully comprehend the nature of the disclosure, and the particular patient's psychological attributes.[125] In coming to any disclosure decision the physician must consider all these factors, and act as a reasonable physician would under the circumstances.

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121. 186 Kan. 393, 350 P.2d 1093 (1960).
122. *Id.* at 409-10, 350 P.2d at 1106. *See also* Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 317 P.2d 170 (1957).
123. *See Survey, supra* note 40.
124. *See* Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).
125. *See generally Informed Consent, supra* note 118.

At this point, it must be noted that the physician's act of informing the patient of his condition is merely a preliminary step in the euthanasia decision. Mere disclosure to the patient of his impending death does not in itself subject the physician to civil liability. Only after the patient relies on the disclosure and consents to the act or non-act of euthanasia does the question of liability arise. Disclosure is a vital part of the patient's informed consent, and this consent may be a defense open to the physician against civil liability for euthanasia.[126]

*Third Party Consent*

An additional complexity in the area of consent arises when the patient is unable to give his consent because he is incompetent, unconscious, or a minor. In *Collins v. Davis*,[127] the patient was in a coma and his wife refused to give consent on his behalf to a life-saving operation. The court refused to abide by this "third party refusal" and ordered the operation to take place, distinguishing *Erickson v. Dilgard*[128] on the grounds that the latter case involved the patient himself refusing the operation. Thus, it appears that third parties may be denied the right to *refuse* treatment on behalf of the incompetent patient. However, it does not appear that a similar denial occurs when third parties are called upon to *consent* on behalf of the patient to treatment.

As a general rule, the physician does not have a duty to disclose information to an incompetent patient concerning his condition.[129] In *Cobbs v. Grant*,[130] the California Supreme Court discussed this rule:

> A patient should be denied the opportunity to weigh the risks only where it is evident he cannot evaluate the data, as for example, where there is an emergency or the patient is a child or incompetent.[131]

The court further discussed who should bear the responsibility when the patient is unable to evaluate the data himself, holding that "the authority to consent is transferred to the patient's legal guardian or closest available relative."[132] Another case involving the same point is *Bonner v. Moran*.[133] There, the court stated:

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126. *See* text accompanying note 102 *supra*.
127. 44 Misc. 2d 622, 254 N.Y.S.2d 666 (1964).
128. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962).
129. *See Informed Consent, supra* note 118, at 1652.
130. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).
131. *Id.* at 238, 502 P.2d at 10, 104 Cal. Rptr. at 514.
132. *Id.*
133. 126 F.2d 121 (D.C. Cir. 1941).

> We think there can be no doubt that a surgical operation is a technical battery, regardless of its results, and is excusable only when there is express or implied consent by the patient; . . . [G]enerally speaking, the rule has been considered to be that a surgeon has no legal right to operate upon a child without the consent of his parents or guardian.[134]

Thus, the rule is that when the patient's own consent is legally invalid because of incompetency or because he is a minor or unconscious, the physician is protected if he secures consent from one legally responsible for the patient's well-being.

Another problem for the physician in this area of third party consent involves the determination of whether the patient is in fact incompetent.[135] The Washington Supreme Court faced this precise issue in *Grannum v. Berard.*[136] Recognizing that competency was at all times a question of fact for the jury, the court stated that the law will presume competency, and the burden of proving incompetency is that of "clear, cogent and convincing evidence."[137] The factors which indicate competency focus on the patient's ability to understand his situation and the risks and alternatives inherent therein. The *logic* of the patient's decision is not itself a factor to be considered, because once deemed competent and informed, the decision rests in his hands.[138]

There are serious difficulties with trying to equate the cases involving the consent of third parties to curative medical treatment with the notion of allowing third parties to consent on behalf of the patient to *life-ending* actions. In the former instance, the third party is consenting to treatment which will replace the "status quo," that is, to replace the patient's former condition of good health. In the latter case, the third party would be consenting to actions which would bring about a major and permanent change. It is questionable whether anyone other than the patient himself has the right to consent to such actions. An essential part of the rationale behind *voluntary* euthanasia involves the preservation of the terminal patient's control over his own destiny.[139]

The "voluntariness" of *voluntary* euthanasia would be infringed upon if third parties were allowed to consent to

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134. *Id.* at 122.

135. This problem does not occur when the patient is a minor. In such cases, reference must be made to the applicable statute stating the age at which an individual becomes competent to enter into legal transactions. If the particular individual has reached this age, he may give a valid consent and is not legally incompetent.

136. 70 Wash. 2d 304, 422 P.2d 812 (1967).

137. *Id.* at 306, 422 P.2d at 814.

138. *See* Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

139. *See Informed Consent, supra* note 118. *See also* Szasz, *Symposium on the Aging Poor*, 23 SYRACUSE L. REV. 45 (1972).

euthanasia on behalf of the terminal patient. Yet, the holding of the recent *Quinlan* case[140] would seem to condone just such a practice. Karen Quinlan herself has never consented to the unplugging of her respirator, but the New Jersey Supreme Court is willing to permit her father, as legal guardian, to consent in her stead. This holding represents the first major decision sanctioning euthanasia, and does so without regard to the expressed wishes of the patient, although under the circumstances it was impossible to obtain the patient's opinion.[141] In regard to the physician's civil liability for acts of euthanasia, the *Quinlan* case represents a significant relaxation of the prior law. By following the specified consent procedure, a physician who disconnects a terminal patient's life-support systems thereby hastening death will avoid civil liability. While this form of *passive* euthanasia is apparently condoned, it seems that legal authorization of *active* euthanasia is still outside the permissive sphere of the law after *Quinlan*.

## SUMMARY OF PROPOSED CHANGES IN THE LAW OF EUTHANASIA

Death has long been a "taboo" subject in Western Society.[142] Other than prohibiting its inducement, society has generally shunned all critical analysis of death. Largely because of this "sociological frigidity," until recently, there has been little action taken to legalize euthanasia. It seems an anomaly, as one writer suggests, that "the use of drugs to relieve pain, although accelerating death, is legally permissible, but the administration of drugs to induce death is not."[143]

However, within the last five years a number of state legislatures have considered bills designed to legalize some forms of euthanasia.[144] For the most part, the subject matter of this legislation includes the authorization of *voluntary-passive* euthanasia[145] and *active* euthanasia if the patient himself consented.[146] Some states have suggested provisions for third party consent when the patient is unable to give his personal consent.[147] Im-

140. *See* text accompanying notes 50-97 *supra*.
141. The court admitted and considered evidence that Karen had told her mother that she wanted to die if such a situation ever occurred.
142. E. KUBLER-ROSS, ON DEATH AND DYING (1973).
143. Gurney, *Is There a Right to Die?—A Study of the Law of Euthanasia*, 3 CUM.-SAM. L. REV. 235, 242 (1972).
144. See *Proposed Euthanasia Statutes: A Philosophical and Legal Analysis*, 3 HOFSTRA L. REV. 115 (1975) [hereinafter cited as *Proposed Statutes*].
145. *See Proposed Statutes, supra* note 144. "Passive" in this sense includes disconnecting life support mechanisms as well as omissions of medical treatment.
146. *Id.*
147. *Id.*

plicit in the legislative considerations, is the requirement that the patient be suffering from a terminal affliction, *i.e.*, "a serious physical disability which is diagnosed as terminal and incurable, from which there is no expectation of regaining health."[148] Although the attending physician makes the initial determination of the patient's condition, most of the legislative proposals require additional verification of the patient's condition by other physicians appointed by the hospital for that purpose.[149]

Such proposed legislation does indicate, however, that lawmakers are beginning seriously to consider statutory changes to the current state of the law on euthanasia.[150] The potential impact of these propositions, on the physician's liability in this area is significant. They would effectively relieve the medical profession of the danger of legal action in a large number of euthanasia situations. The legislation would allow the patient rather than the physician to assume the role of primary decision-maker, providing "a vehicle for individual choice; it would also protect one who would not choose to elect the remedy."[151]

Equally prevalent are strong arguments against any form of euthanasia. First, euthanasia involves the taking of life, and an essential policy of society is the protection of life. This policy of protecting life is reflected in the criminal statutes of all fifty states, which punish the intentional taking of another's life without lawful justification.

Second, the possibility always exists for erroneous diagnoses of a patient's condition. One noted authority who expounds this argument questions whether the potentially premature and unnatural death of one individual is worth relieving the pain and suffering of any number of other individuals.[152] Another consideration closely related to this argument is the fact that medical science might find a cure for the patient's condition in time to save his life.[153]

Third, and perhaps most significant is the "wedge theory." This position concerns the *implications* of legalizing euthanasia, contending that the permission of euthanasia, a death-oriented concept, would open the door to other practices such as killing

148. *Id.* at 131.
149. *Id.*
150. *Id. See also* Note, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALBANY L. REV. 826 (1975).
151. Note, *Voluntary Euthanasia: A Proposed Remedy*, 39 ALBANY L. REV. 826, 835 (1975).
152. *See* Kamisar, *Some Non-Religious Views Against Proposed Mercy Killing Legislation*, 42 MINN. L. REV. 969 (1958) [hereinafter cited as Kamisar].
153. *See* Vodiga, *Euthanasia and the Right to Die—Moral, Ethical and Legal Perspectives*, 51 CHI.-KENT L. REV. 1 (1974).

those individuals whom society has found to be "worthless."[154] Consider the effect of legalized euthanasia on a society concerned with the preservation of life. One author has suggested the following changes in values which might materialize:

> Contrast the attitudes and manners which the motive of relieving pain engenders, with those likely consequent upon a grim determination to kill. If the purpose were explicitly to kill, would not there be a profound difference in the very way one would grasp the syringe, the look in the eye, the words that might be spoken or withheld, those subtle admixtures of fear and hope that haunt the death-bed scene? And would not the consequences be compounded at least for the physician as he killed one such patient after another? The line between civilized and savage in men is fine enough without jeopardizing it with euthanasia . . . . The line might well not be maintainable under a regime of direct intentional killing.[155]

## CONCLUSION

In summary, there are persuasive arguments both for and against euthanasia. The finality of the patient's affliction, his right to determine the time of his death,[156] and the expense and hardship to his loved ones are persuasive contentions for the legalization of at least some forms of euthanasia. Conversely, the sanctity of life in all forms,[157] the danger of mistaken diagnoses or the possibility of recovery, and the specter of extending "mercy-killing" beyond the realm of the terminally ill patient all pose reasoned arguments against euthanasia.

Caught in the middle of this moral and legal dilemma is the physician. His involvement in the euthanasia decision is deep and his concern in the controversy correspondingly great. The recent trend of the law, as evidenced by the growing number

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154. Proponents of the wedge theory use historical examples to illustrate their point, such as the situation which existed in Nazi Germany:

> The beginnings at first were merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy of being lived. This attitude in its early stages confined itself to the severely and chronically sick. Gradually the sphere of those to be included . . . was enlarged to encompass the socially unproductive, the idealogically unwanted, the radically unwanted, and finally all non-Germans. But it is important to realize that the infinitely small wedged-in level from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitable sick.

Alexander, *Medical Science Under Dictatorship*, 241 N.E.J. MED., *cited* in Kamisar, *supra* note 152 at 115-16.

155. Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723, 742 (1973).

156. *See* Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

157. However, this sanctity of life in all forms does not extend at the present time to that of unborn life. *See* Roe v. Wade, 410 U.S. 113 (1973).

of proposed statutes advocating the legalization of euthanasia in some forms, and by the *Quinlan* case, promises some relief to physicians from both criminal and civil liability. However, exact boundaries of the law have yet to be clearly defined and strong arguments may yet be made against *involuntary* and *active* forms of euthanasia. It does appear that as to *passive* euthanasia, the law is currently lending a sympathetic ear toward the physician's plight.

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