

LIMITS TO DEATH WITH DIGNITY

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He who saves a man against his will as good as murders him.

-Horace,
Ars Poetica (13-8 B.C.)

I. INTRODUCTION

A 72 year-old man suffering from two gangrenous legs may refuse to have his legs amputated, even though the consequence almost certainly will be death.¹ A patient suffering from leukemia may decline chemotherapy when the treatment will not cure the leukemia and may cause painful side-effects, and without the treatment the patient will die within a few months.² A terminally ill patient also may have a respirator removed, even though the removal will hasten his death.³ The proliferation of "right to die" cases has led some courts to permit incurable and suffering patients to have their life-support equipment withdrawn, even though the patients were not terminal.⁴

The interests of a patient in self-determination, privacy rights, and the liberty to live and die according to his own values generally permit a terminal or elderly patient to refuse any treatment. The same interests should permit most competent, suffering patients to choose the course of treatment, or non-treatment, they desire, even if a consequence will be the patient's death. Patients who refuse treatment and thereby hasten their deaths also should

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1. See *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978); see also *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978) (daughter of 77 year-old widow not appointed guardian for purpose of consenting to amputation of widow's gangrenous leg after widow refuses).

2. *Cf. Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (guardian *ad litem* recommends not treating mentally retarded patient and court orders withholding of treatment; court notes that an incompetent patient must be able to decline certain treatments as if he were competent).

3. *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980). Terminally ill patients have a "terminal condition," which is defined in some statutes. See, e.g., *UNIFORM RIGHTS OF THE TERMINALLY ILL ACT* § 1(9), 9B U.L.A. 612 (1987) ("Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.").

4. See *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (patient has right to have ventilator removed); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (court allows patient to refuse continued forced feeding).

be entitled to receive "treatments" that will relieve their suffering, even if those treatments will hasten or cause their deaths.

Despite the claims of some commentators,⁵ a line can be drawn that will allow patients to avoid suffering through the use of voluntary euthanasia, while protecting from involuntary euthanasia those who wish to live.⁶ Only competent patients who are expected to die soon without treatment should be permitted to elect euthanasia. A hearing must be held to ensure that the choice is informed and voluntary, while the availability of criminal prosecution when foul play is suspected will provide additional deterrence from abuse. These safeguards will make euthanasia available to those for whom it is most important, without permitting its involuntary application.

The rationale for permitting patients to "die with dignity" is derived from common law rights to self-determination and constitutional rights to privacy. It applies only when the choice is made by the patient. The same rights protect patients from involuntary euthanasia.

II. THE PRIMARY INTERESTS AND FACTORS IN THE PATIENT'S CHOICE

A. *The Patient's Interests*

Individuals have strong liberty interests in being free to make their own decisions regarding the course of their medical treatment and in preventing unwanted interference with their bodies. The Massachusetts Supreme Judicial Court has described this interest as "protect[ing] the patient's status as a human being."⁷ By not protecting an individual's choice, the law decreases the value of life.⁸ This liberty interest has been recognized by courts as stemming both from a common law right of self-determination and from state and federal rights to privacy.

5. See, e.g., Koop & Grant, *The "Small Beginnings" of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing*, 2 NOTRE DAME J. OF L., ETHICS & PUB. POL'Y 585, 589 (1986) (passive euthanasia will lead to the intentional killing "of those whose lives are considered of insufficient value to maintain"); Gelfand, *Euthanasia and the Terminally Ill Patient*, 63 NEB. L. REV. 741, 756-69 (1984) (presents 12 arguments for preservation of life, including the danger that voluntary euthanasia will lead to involuntary euthanasia).

6. Throughout this paper, "mercy killing," "active euthanasia," and "euthanasia" (unmodified) refer to the administration of a life-shortening agent with the intention of causing death to end suffering. "Involuntary euthanasia" refers to euthanasia administered without the consent of the patient. "Passive euthanasia" refers to the situation where a patient hastens death by refusing medical treatment or by directing that life-sustaining treatment be discontinued or withdrawn.

7. *Saikewicz*, 373 Mass. at 739, 370 N.E.2d at 424.

8. *In re Conroy*, 98 N.J. 321, 350, 486 A.2d 1209, 1223-24 (1985); *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426.

A common law right of self-determination was first acknowledged by the Supreme Court nearly 100 years ago: "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."⁹ This means that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."¹⁰

This right of self-determination and the need for consent to treatment must provide a patient the right to refuse treatment or the right provides no practical benefit and is meaningless.¹¹ Although a patient may refuse treatment because it will reduce his ability to enjoy life,¹² the "right to be let alone" does not require the patient to have a reason. "That one is a person, unique and individual, is enough."¹³ In fact, requiring a "good" reason would be inconsistent with the right of self-determination. A patient would not be autonomous in determining the course of his treatment if others could overrule what they considered to be an "insufficient" reason for refusing treatment.

Many state courts also have based a patient's right to self-determination on state or federal constitutional rights to privacy.¹⁴ These medical rights to privacy have been expressed

9. *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (Supreme Court rules that the trial court may not order the plaintiff in a civil action to submit to a surgical examination to determine the extent of her injuries without her consent).

10. *Schloendorff v. New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (Cardozo, J.) (a patient sues after consenting to an examination but not to an operation, yet the operation is performed anyway).

11. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983) ("The obvious corollary to this principle [that treatment without consent constitutes battery] is that a competent adult patient has the legal right to refuse medical treatment.").

12. See, e.g., *Quackenbush*, 156 N.J. Super. at 288, 383 A.2d at 788 (patient refuses amputation; wants to avoid the need for nursing care and wants to return to the trailer where he has lived the past 10 years).

13. *In re Brown*, 478 So. 2d 1033, 1040 (Miss. 1985) (patient refuses blood transfusions as part of her surgery; decision based on free exercise of religion interest, as well as right to be let alone based on common law and state and federal constitutions).

14. See, e.g., *In re Quinlan*, 70 N.J. 10, 39-40, 355 A.2d 647, 663, cert. denied, 429 U.S. 922 (1976); *Saikewicz*, 373 Mass. at 739, 370 N.E.2d at 424; *In re Colyer*, 99 Wash. 2d 114 at 120, 660 P.2d 738, 742 (1983); *Severns v. Wilmington Medical Center*, 421 A.2d 1334, 1347 (Del. 1980); *Rasmussen v. Fleming*, 741 P.2d 674, 682 (Ariz. 1987).

Unfortunately, most courts after *Quinlan* tend to rely on *Quinlan*, which did not really discuss why the right to privacy includes a right to decline medical treatment. In *Quinlan*, the court merely stated that "[p]resumably this right [to privacy] is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." 70 N.J. at 40, 355 A.2d at 663. The *Quinlan* court provided no discussion as to why the New Jersey constitutional right to privacy applied here, stating only: "Nor is such right of privacy forgotten in the New Jersey Constitution." *Id.*

as originating in fourth amendment privacy concerns, fourteenth amendment liberty concerns, and as an extension of the penumbral right to privacy recognized in *Griswold v. Connecticut*.¹⁵

The Arizona Supreme Court expressed the right most powerfully when the court placed the right under the state constitution's protection of privacy. Although the state constitutional provision normally was applied in a search and seizure context, "[a]n individual's right to chart his or her own plan of medical treatment deserves as much, if not more, constitutionally-protected privacy than does an individual's home or automobile."¹⁶ Justice Brandeis expressed the basis for this view nearly 60 years earlier, in discussing the breadth of fourth amendment protection:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. . . . They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. 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.¹⁷

The right also has been described simply in standard right to privacy terms. As one commentator described it, "no more basic aspect of personal privacy can be found than bodily integrity, and this interest is entitled to concomitant constitutional protection."¹⁸ Although no family planning is involved, this interest can be as personal and private as decisions to use contraceptives, which were protected in *Griswold*. Decisions as to medical treatment fundamentally affect an individual and primarily involve only the individual, making the decision extremely private. Also, these decisions are very personal, involving an individual's choice as to how to lead his life and, therefore, are especially appropriate for protection under a right to privacy.¹⁹ Nonetheless, the Supreme Court has not ruled on the existence of this right.

15. 381 U.S. 479 (1965) (law prohibiting use of contraceptives violates right of privacy).

16. *Rasmussen*, 741 P.2d at 682. The Arizona constitution provides that: "No person shall be disturbed in his private affairs, or his home invaded, without authority of law." ARIZ. CONST. art. II, § 8.

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

18. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 241 (1973) [hereinafter Cantor, *A Patient's Decision*].

19. See Delgado, *Euthanasia Reconsidered: The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474 (1975).

The right to refuse treatment also could be included under fourteenth amendment liberty interests. Justice Douglas, concurring in *Doe v. Bolton*,²⁰ discussed three rights that "come within the meaning of the term 'liberty' as used in the Fourteenth Amendment."²¹ The third was "the freedom to care for one's health and person, [and] freedom from bodily restraint or compulsion"²² The right to refuse treatment is a necessary element of this freedom.²³ Whatever its exact basis, the right to self-determination has strong foundations under the common law and should not be abridged lightly.

B. The Primary State Interests

Courts have recognized four state interests to be weighed against the patient's interest in self-determination: first, the preservation of the lives of the patient and others; second, the prevention of suicide; third, the protection of innocent third parties; and fourth, the protection of the ethics of the medical profession.²⁴

The interest in the preservation of life generally is considered "the most significant."²⁵ When the patient will die soon anyway, this interest is less significant, but the state still has an interest

A New York appellate court saw the right to decline treatment as a natural extension of the right to terminate a pregnancy provided by *Roe v. Wade*, 410 U.S. 113 (1976). "By parity of reasoning, the constitutional right to privacy . . . encompasses the freedom of the terminally ill but competent individual to choose for himself whether or not to decline medical treatment where he reasonably believes that such treatment will only prolong his suffering needlessly, and serve merely to denigrate his conception of the quality of life. The decision by the incurably ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a 'fundamental' decision in their lives, that it is virtually inconceivable that the right of privacy would *not* apply to it. Individuals have an inherent right to prevent 'pointless, even cruel, prolongation of the act of dying.'" *In re Eichner*, 73 A.D.2d 431, 458-59, 426 N.Y.S.2d 517, 539 (1980) (emphasis in original) (quoting *In re Dinerstein*, 6 Mass. App. Ct. 466, 471, 380 N.E.2d 134, 137 (1978)), *aff'd on narrower grounds sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

20. 410 U.S. 179 (1973) (Court strikes down a statute for imposing undue restrictions on the right to obtain an abortion).

21. *Id.* at 211-12 (Douglas, J., concurring).

22. *Id.* at 213 (Douglas, J., concurring).

23. See Cantor, *A Patient's Decision*, *supra* note 18, at 241 (the right to refuse treatment involves a "right to self determination, meaning liberty to choose a life-style or course of conduct. This interest has a constitutional dimension and is covered by the fourteenth amendment guarantee of liberty.").

24. See, e.g., *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425; *Conroy*, 98 N.J. at 348-49, 486 A.2d at 1223; *Colyer*, 99 Wash. 2d at 122, 660 P.2d at 743; *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225.

25. *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425.

in preserving the sanctity of life and in not cheapening its value.²⁶

These concerns with the sanctity and value of life become most significant as the asserted right of self-determination comes closer to a patient seeking euthanasia. In that case, society actually condones the taking of a life because the life is not considered worth continuing. Considering the atrocities committed in Nazi Germany, "no just society can risk the profound evil of devaluing the life of any human being, no matter how profoundly that life may be impaired."²⁷

However, human life also is devalued if individuals are denied the ability to determine the course of their lives. Therefore, the state interest will not necessarily be impaired if patients have the right to choose.

The interest in preventing suicide requires determining when a patient's conduct is equivalent to committing suicide. Courts frequently consider whether the patient has a "specific intent to die, and . . . to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death."²⁸ The answer to these two considerations will not always be clear.

This interest has been described as necessary for "the prevention of *irrational* self-destruction."²⁹ But, although suicide prevention is an important interest, even a decision that is considered to be suicide might not implicate this concern. A patient's decision that is equivalent to suicide still might be a considered, rational decision.

Even if technically it is not suicide when the patient lacks a specific intent to die or did not set the death producing agent in motion, the state's interests in preserving the lives of other people and preserving the value of human life still apply when a patient refuses treatment. The state still may have an interest in preventing the patient's death, as is apparent from laws relating to suicide. Although suicide is not a crime in any state, attempted

26. *Id.* at 742, 370 N.E.2d at 425-26; *Conroy*, 98 N.J. at 349, 486 A.2d at 1223.

Although a significant interest, the sanctity of life has never been considered to trump all other interests. Wars, for example, are fought to protect interests such as liberty or democracy, and by their very existence reflect a willingness to sacrifice the lives of some. Also, safety regulations accept the possibility of the loss of some lives. See Cantor, *A Patient's Decision*, *supra* note 18, at 244 & n.87.

27. Koop & Grant, *supra* note 5, at 634; see also Gelfand, *supra* note 5, at 763-66.

28. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; see also *Conroy*, 98 N.J. at 350-51, 486 A.2d at 1224; *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743.

29. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11 (emphasis added); see also Cantor, *A Patient's Decision*, *supra* note 18, at 256 ("The principal objective of governmental intervention in the area of suicide is to secure assistance for the individual. Such assistance is appropriate because many suicide attempts are the product of rash, unbalanced, or confused judgments.").

suicide is a crime in some states, as is aiding and abetting a suicide.³⁰ The states with these laws have expressed an interest in preserving individuals' lives by discouraging people from aiding a suicide and thereby discouraging the committing of suicide. Additionally, the states are concerned that "the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim."³¹

From this perspective, the specific intent and conduct of the patient are not necessary for the state to maintain its interest in preserving the individual's life. That the patients' decision will lead to his death is sufficient. However, the factors that reduce this interest when the patient's right to self-determination will be impinged still apply.

The state's interest in protecting innocent third parties looks at the impact that the patient's decision will have on the family of the patient, especially those who are dependent on the patient (e.g., minor children), on hospital workers, and on other patients.³² This interest was significant in many of the Jehovah's Witnesses cases, where the courts required patients to accept blood transfusions, despite their religious objections, to protect the interests of the patients' young children.³³ However, in some cases, the patients' children may be benefitted if they are not subjected to the emotional and financial burden of watching a parent suffer for many years.³⁴

The final state interest, protecting the ethics of the medical profession, is based on a physician's obligation to "treat the sick and prevent the loss of life."³⁵ In addition, if physicians are as-

30. See *In re Joseph G.*, 34 Cal. 3d 429, 433-34, 667 P.2d 1176, 1178-79, 194 Cal. Rptr. 163, 165-66 (1983) (court considers suicide and murder laws in determining whether the defendant, who survived after driving a car off a cliff as part of a suicide pact with his passenger, murdered his passenger or aided and abetted his passenger's suicide); MODEL PENAL CODE § 210.5 (1980) (establishing a crime of "Causing or Aiding Suicide" but no crime for suicide or attempted suicide).

31. MODEL PENAL CODE § 210.5 comment 5 (1980).

32. See Cantor, *A Patient's Decision*, *supra* note 18, at 249-53.

33. See, e.g., Application of the President and Directors of Georgetown College, 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752, 754 (D. Conn. 1965); see also *In re Farrell*, 108 N.J. 335, 352, 525 A.2d 404, 412 (1987) (rejects interest of minor children in this case, but notes: "When courts refuse to allow a competent patient to decline life-sustaining treatment, it is almost always because of the state's interest in protecting innocent third parties who would be harmed by the patient's decision.").

34. See *Farrell*, 108 N.J. at 353, 529 A.2d at 413; see also *In re Osborne*, 294 A.2d 372 (D.C. 1972) (patient has provided for future care of his children); Cantor, *A Patient's Decision*, *supra* note 18, at 251-54.

35. Morris, *Compelling a Competent Adult to Submit to Medical Treatment: An Argument Against Antidysthanasia*, 16 FORUM 911, 917 (1981). Morris defines "antidysthanasia" as "the process of allowing death or hastening one's death by declining medical treatment." *Id.* at 912.

sociated with sanctioning death, then patients' trust of physicians as healers could be undermined. This becomes more compelling the closer that medical decisions come to active euthanasia.³⁶

However, as many courts have acknowledged, "physicians distinguish between curing the ill and comforting and easing the dying; . . . they refuse to treat the curable as if they were dying or ought to die, and . . . they have sometimes refused to treat the hopeless and dying as if they were curable."³⁷ At least with regard to dying patients, medical ethics would approve the refusal of treatment beyond what is needed to relieve suffering.³⁸

The protection of medical ethics also requires that "[h]ealth care professionals . . . may decline to provide a particular option because that choice would violate their conscience or professional judgment"³⁹ Therefore, medical professionals at times may decline to take active steps that will lead to a patient's death.⁴⁰ As decisions come closer to looking like euthanasia, medical ethics and the interest in preserving the appearance of physicians as healers will conflict with patients' desires. However, in most cases, a patient will be able to obtain the treatment or non-treatment he desires without requiring a health care professional to act against the professional's wishes and judgment beyond permitting the patient to decline certain treatments or to switch to a different physician or another facility.⁴¹

C. Other Relevant Concerns

Three other concerns influence whether a patient's interest in self-determination will be honored. First, a patient's decision should be governed by the principles of informed consent; second, the laws against murder may apply, regardless of whether they

36. See Gostin, *A Right to Choose Death: The Judicial Trilogy of Brophy, Bouvia, and Conroy*, 14 LAW, MED. & HEALTH CARE 198, 200 (1986); Capron, *Legal and Ethical Problems in Decisions for Death*, 14 LAW, MED. & HEALTH CARE 141, 144 (1986).

37. Quinlan, 70 N.J. at 47, 355 A.2d at 667; see also Saikewicz, 373 Mass. at 743, 370 N.E.2d at 426; Colyer, 99 Wash. 2d at 123, 660 P.2d at 743.

38. See, e.g., *Rasmussen*, 741 P.2d at 684; *Brophy v. New England Sinai Hospital*, 398 Mass. 417, 439-40 & n.38, 497 N.E.2d 626, 638 & n.38 (1986) (noting the agreement in this regard of the American Medical Association and the Massachusetts Medical Society).

39. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 3 (1983) [hereinafter PRESIDENT'S COMMISSION].

40. See *Brophy*, 398 Mass. at 441, 497 N.E.2d at 639 ("It would be particularly inappropriate to force the hospital . . . to take affirmative steps to end the provision of nutrition and hydration A patient's right to refuse medical treatment does not warrant such an unnecessary intrusion upon the hospital's ethical integrity in this case.")

41. See, e.g., *id.* at 440-41, 497 N.E.2d at 639 (the hospital was willing to assist in the transfer of the patient to another facility and would not be compelled to violate its ethical principles by withholding nutrition from the patient).

should; and third, the state may have specific institutional interests in certain situations.

The informed consent doctrine, based on principles of self-determination, requires physicians not only to obtain the consent of the patient before providing treatment, but also to inform the patient of the risks involved and the possible alternatives.⁴² This doctrine extends to refusals of treatment. Before a patient should be permitted to refuse treatment or make any other decision, he should know and understand his current medical status, the possible interventions, the likely consequences of each intervention or of non-intervention, and, in most cases, "a professional opinion as to the best alternative."⁴³ Inaccurate or incomplete information limits a patient's ability to understand what is at stake and to make a decision that corresponds to the patient's values rather than to the physician's.⁴⁴

One potential difficulty is in determining when the patient fully understands the consequences and has made a reasoned decision. A decision that seems "unwise, foolish or ridiculous" might still be reasoned and deserving of respect.⁴⁵ However, especially when the patient's life is at stake, hasty decisions must be avoided, as must unclear decisions by partially disabled patients.⁴⁶

State laws against murder, while not directly applicable to the patient's decision regarding his own treatment, may restrict what others can do to assist the patient. At least active euthanasia falls squarely within the scope of most state laws against murder, which involve purposefully or knowingly causing the death of another.⁴⁷

The *Quinlan* court, by finding a constitutional right to have treatment withdrawn, decided that the patient could not be charged with violating any criminal laws. "The constitutional protection extends to third parties whose action is necessary to

42. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir.) (malpractice action for failure to inform patient of a small risk of paralysis from an operation), *cert. denied*, 409 U.S. 1064 (1972).

43. PRESIDENT'S COMMISSION, *supra* note 39, at 51-52; see also *Farrell*, 108 N.J. at 354, 529 A.2d at 413 (the patient must be "properly informed about his or her prognosis, the alternative treatments available, and the risk involved in the withdrawal of the life-sustaining treatment").

44. PRESIDENT'S COMMISSION, *supra* note 39, at 52.

45. *In re Yetter*, 62 Pa. D. & C.2d 619, 623 (1973) (patient refuses to consent to surgery).

46. See *In re Kerr*, 517 N.Y.S.2d 346, 348 (N.Y. Sup. Ct. 1986) (patient's apparent annoyance with feeding tube is not sufficient to convince court that the patient wants the tube removed and has considered the consequences).

47. See *Lacewell, A Comparative View of the Roles of Motive and Consent in the Response of the Criminal Justice System to Active Euthanasia*, 6 MED. & L. 449, 453 (1987) (looking at the Model Penal Code).

effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime."⁴⁸ However, this analysis is applicable only if the right is considered to be constitutionally based. Also, a patient's right to refuse treatment will not necessarily protect all activities designed to aid the patient in exercising that right.⁴⁹

Finally, at times, a state may have specific institutional interests that will restrict a patient's right to self-determination. For example, the state's interest in orderly prison administration may tip the balance against permitting a prison patient to refuse treatment.⁵⁰ However, in another case, the state's interest in prosecuting an alleged murderer was not sufficient to permit it to force a prosecution witness to receive blood transfusions in conjunction with necessary surgery. Although the witness's chances were much worse without the blood, her *right* to refuse certain treatment "prevails against mere *interests*, public or private, no matter how compelling."⁵¹ In most cases, these institutional interests will not apply.

III. BALANCING THE INTERESTS IN REFUSING TREATMENT

Courts over the last ten years generally have been unwilling to deny a patient the right to refuse treatment. One commentator could find:

no decision by the highest court of any state (and few if any by an appellate court below the highest rung) that does not conclude that a competent adult patient has the right to decline *any and all* treatments, life-sustaining or otherwise, provided that doing so does not directly threaten the life or well-being of other persons.⁵²

48. *Quinlan*, 70 N.J. at 52, 355 A.2d at 670; see also *Colyer*, 99 Wash. 2d at 138, 660 P.2d at 751.

49. An illegal action, such as murder, associated with a protected right implicates additional and independent state interests, which may justify restrictions. This limitation is comparable to limits on first amendment rights. For example, while speech is protected, communicative conduct is not. See, e.g., *United States v. O'Brien*, 391 U.S. 367 (1968) (conviction for burning draft-card as part of anti-war protest upheld; governmental interest in regulating the non-speech elements justifies some limitations on speech elements of the conduct).

50. See *Commissioner of Correction v. Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979) (prisoner refuses dialysis treatments in order to protest his confinement in a medium rather than a minimum security prison; *Von Holden v. Chapman*, 87 A.D.2d 66, 450 N.Y.S.2d 623 (1982) (prisoner attempts to commit suicide by starvation).

51. *In re Brown*, 478 So. 2d 1033, 1036 (Miss. 1985) (emphasis added). The court distinguished rights from interests, where rights are "subject to compromise only when they collide with conflicting rights vested in others." *Id.*

52. Capron, *supra* note 36, at 142 (emphasis in original).

Almost all of these cases involve a terminal or elderly patient who does not have long to live.⁵³ The courts tend to emphasize that the state interests are weak because the patient will die soon, that discomfort of or intrusion upon the patient is required to provide the treatment, that medical ethics favor comforting the dying, and that death will be the result of the underlying disease that caused the condition.⁵⁴

Many other cases involve incompetent patients, usually in a persistent vegetative state, where the court permits a guardian to decide in order that an incompetent patient not be denied the rights of a competent patient. Again, the state interests are found to be too weak to overcome the patient's interests.⁵⁵

The more difficult problem involves the patient who will not die in the near future unless treatment is withheld, but is suffering and wishes to decline or discontinue the treatment. Generally, the treatment involves a respirator or artificial nutrition. Without the expected imminent death of the patient, a balancing is necessary because the state's interests are not weakened as much. Nonetheless, if the patient's rights to self-determination are to be given full weight, then the patient's interests must prevail.

A. The Patient's Perspective

In two cases involving this fact pattern that were decided in California, the court ruled for the patient. In *Bartling v. Superior Court*,⁵⁶ the court ruled that "a competent adult patient, with serious illnesses which are probably incurable but have not been diagnosed as terminal, has the right . . . to have life-support equipment disconnected despite the fact that withdrawal of such devices will surely hasten his death."⁵⁷ The court decided the case despite the death of the patient prior to the decision. It stated that

53. See, e.g., *Satz v. Perlmuter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (1980) (terminally ill patient on respirator will die soon anyway); *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978) (77 year-old widow refuses amputation of gangrenous leg); *In re Requena*, 213 N.J. Super. 475, 517 A.2d 886 (N.J. Super Ct. Ch. Div.) (competent patient dying of amyotrophic lateral sclerosis is allowed to refuse artificial nutrition), *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (N.J. Super. Ct. App. Div. 1986); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987) (competent, terminally-ill patient living at home may have a respirator withdrawn).

54. See, e.g., *Satz*, 362 So.2d 160 (Fla. Dist. Ct. App. 1978); *Farrell*, 108 N.J. 335, 529 A.2d 404 (1987).

55. See, e.g., *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (mentally retarded patient suffering from leukemia; chemotherapy could cause side-effects and discomfort); *Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (incompetent patient would die within a year and is very uncomfortable); *Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (patient in persistent vegetative state is subject to highly intrusive care with no chance for recovery).

56. 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).

57. *Id.* at 189, 209 Cal. Rptr. at 220-21.

"if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors."⁵⁸ Furthermore, the court held that the patient's death would not be suicide because disconnecting the respirator "would merely have hastened his inevitable death by natural causes."⁵⁹

A year and a half later, in *Bouvia v. Superior Court*,⁶⁰ the same court was forced to render a decision when the patient had not died and was not terminally ill, but was subjected to "dehumanizing" treatment by the "forced intrusion of an artificial mechanism into her body against her will."⁶¹ The court followed *Bartling* and ruled that the patient's decision was not "subject to being overridden by medical opinion."⁶² Medical ethics did not necessarily conflict with her desires. The American Medical Association had declared that "[t]he 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 . . . should prevail."⁶³ Even though *Bouvia* might live for 20 years with the help of the feeding tube, the decision was still hers to make: "It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or more accurately, endure, for '15 to 20 years.' We cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone."⁶⁴ Also, *Bouvia's* decision was considered not to be the equivalent of suicide. Rather, she was accepting an earlier death by allowing nature to take its course and asserting her "right to live out the remainder of her natural life in dignity and peace."⁶⁵

Other interests of a patient in a position similar to *Bouvia* further strengthen the argument that the patient should be permitted to reject life-preserving treatment. These can be divided into interests of concern only to the patient and interests involving others.

As the *Bouvia* court discussed, a patient has a general interest in self-determination, which is at least as strong and probab-

58. *Id.* at 195, 209 Cal. Rptr. at 225.

59. *Id.* at 196, 209 Cal. Rptr. at 225.

60. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

61. *Id.* at 1134, 225 Cal. Rptr. at 299 (the patient was almost completely immobile and unable to care for herself as a result of cerebral palsy and quadriplegia; she sought removal of a nasogastric tube).

62. *Id.* at 1137, 225 Cal. Rptr. at 301.

63. *Id.* at 1141, 225 Cal. Rptr. at 303 (quoting a statement by the Council on Ethical and Judicial Affairs of the American Medical Association adopted on March 15, 1986, entitled "Withholding or Withdrawing Life Prolonging Medical Treatment").

64. *Bouvia*, 179 Cal. App. 3d at 1143-44, 225 Cal. Rptr. at 305.

65. *Id.* at 1144, 225 Cal. Rptr. at 305, 306.

ly stronger for the suffering patient than for the dying patient or any other patient. Modern medical technology, with its ability to extend life, has created situations that society has not yet determined how to resolve. As one justice on the New Jersey Supreme Court described the problem, "science has forced medical choices upon us that we have yet fully to resolve in the context of our values."⁶⁶

Not all patients are enamored of the prospect of surviving only through reliance on a machine. "Some patients . . . want no part of a life sustained only by medical technology. Instead they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity."⁶⁷ A patient "may well . . . wish to avoid, as one writer vividly put it, 'The ultimate horror [not of] death but the possibility of being maintained in limbo, in a sterile room, by machines controlled by strangers.'⁶⁸ If the right to self-determination is compelling in any situation, then it must be compelling under these particular conditions.

In essence, a patient wishes merely to "preserve his humanity, even if to preserve his humanity means to allow the natural processes of a disease or affliction to bring about a death with dignity."⁶⁹ The patient will be choosing death sooner rather than later, to avoid a life filled with pain, frustration, helplessness, and hopelessness, dependent on machines or other people.⁷⁰ This is a fundamental element of the right to self-determination, the exercise of which depends on how an individual patient values a life of suffering, under permanently disabling conditions, relative to a quick death. "The choice, ultimately, is subjective . . . and should not be judged by others. The most intimate final decision is whether to continue living. It is not within the competence of the state, the judiciary, or the medical profession to measure the correctness of that decision."⁷¹

Under the above logic, whether the patient is "terminal" is irrelevant. The patient will die a "natural" death without the treat-

66. *In re Peter*, 108 N.J. 365, 387, 529 A.2d 419, 430 (1987) (O'Hern, J., dissenting).

67. *Rasmussen v. Fleming*, 741 P.2d 674, 678 (Ariz. 1987).

68. *In re Torres*, 357 N.W.2d 332, 340 (Minn. 1984) (second set of brackets in original) (quoting Steel, *The Right to Die: New Options in California*, 93 CHRISTIAN CENTURY (July-Dec. 1976)); cf. *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 6, 426 N.E.2d 809, 812 (Ohio Ct. Com. Pleas 1980) (patient in a persistent vegetative state will die within a few years; the court frames the question as "how long will society require Mrs. Leach and others similarly situated to remain on the threshold of certain death suspended and sustained there by artificial life supports.").

69. *Brophy*, 398 Mass. at 434, 497 N.E.2d at 635.

70. See *Requena*, 213 N.J. Super. at 482, 517 A.2d at 890; *Bouvia*, 179 Cal. App. 3d at 1144, 225 Cal. Rptr. at 305-06.

71. Gostin, *supra* note 36, at 199; see also PRESIDENT'S COMMISSION, *supra* note 39, at 44.

ment and to deny him that option is to interfere greatly with his autonomy as a human being.⁷² Also, the "terminal" distinction is too imprecise. In practice, the position of the non-terminal, suffering patient is no different than that of the patient suffering a slow and lingering death who is deemed terminal; the continued long-term survival of either is not especially certain.⁷³ Therefore, to permit only terminal patients to refuse treatment is to create a distinction that is meaningless from the patient's perspective. Furthermore, it would lead to disputes over when a patient actually is terminal, which would be likely to interfere with physician-patient relationships.

The patient required to remain on life-support systems also is forced to remain in the hospital or attached to a machine, or is required to accept treatment, possibly including the injection of foreign substances, all against his will. All of these procedures seriously restrict the patient's liberty, beyond his interest in self-determination, without the patient having done anything wrong. A hospital or physician should not be able to exercise this power so easily, especially considering the self-determination and privacy interests involved.⁷⁴

Even if the patient is not forced to remain in the hospital against his will, the patient would be required to accept hospital care only under conditions unacceptable to the patient. As the Mississippi Supreme Court recognized, by entering a hospital a patient does not waive the right to object to particular treatments. A patient must be free to impose conditions on her care.⁷⁵

The patient has additional interests based on the effects that his continued existence will have on others. The patient may wish to spare family members the emotional costs of watching him suffer through an incurable disease and the financial costs of paying for protracted treatment. The patient also may wish to be remembered as he was, before becoming subject to the debilitating disease from which he now suffers. A quicker death may enable the patient to avoid being remembered by his suffering.

72. See, e.g., *Brown*, 478 So.2d at 1040 (a patient may refuse blood transfusions without a reason; "that one is a person, unique and individual, is enough.").

73. See *Bartling*, 163 Cal. App. 3d at 189, 209 Cal. Rptr. at 220-21 (Bartling had not been diagnosed as "terminal" but died prior to the court's decision); see generally PRESIDENT'S COMMISSION, *supra* note 39, at 25-26 (recognizing the difficulty in determining when someone will die).

74. Cf. *Rochin v. California*, 342 U.S. 165, 172 (1952) (Court reverses conviction of a prisoner based on the use of two morphine capsules discovered after the prisoner's stomach was pumped involuntarily to induce vomiting; the Court found this to be "conduct that shocks the conscience," and a violation of due process.)

If this conduct by the state violates due process then a patient should be protected from similar intrusions by private parties without at least a hearing and a compelling justification.

75. *Brown*, 478 So. 2d at 1041; see also *Bouvia*, 179 Cal. App. 3d at 1145, 225 Cal. Rptr. at 306 (the hospital "may not deny [the patient] relief from pain and suffering merely because she has chosen to exercise her fundamental right to protect what little privacy remains to her.").

B. *Balancing the State Interests*

The four state interests—in the preservation of life, the prevention of suicide, the protection of innocent third parties, and the protection of medical ethics—when balanced against the patient's interest in self-determination, are stronger when the patient is not terminal than when he is terminal, but they generally will not prevail.

1. *The Preservation of Life*

The state interest in the preservation of life is stronger in the case of a non-terminal patient since the patient is expected to live much longer. In some cases, the patient could live for many years. Moreover, since the patient is not actually considered to be dying, the value attached to life could appear to be lessened significantly by permitting the patient to die.

When a court first attempted to balance the patient's interest in self-determination against the state's interest in the preservation of life, in *In re Quinlan*,⁷⁶ the court observed that "the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."⁷⁷ Although the prognosis for a non-terminal patient is not as dim as the prognosis for a terminal patient, the suffering, non-terminal patient is far from leading a "normal" life. Moreover, the degree of bodily invasion still is probably quite high. For a cognitive patient, in fact, a particular bodily invasion may be worse than for a comatose patient like Ms. Quinlan who is unaware of her condition. In addition, the terminal/non-terminal distinction is too imprecise to support an assignment of different weights to the state interests according to the different prognoses.

To permit the state interest in the preservation of life to prevail in all cases where the patient is non-terminal, would be to disregard a basic premise of the American system of government. "The notion that the individual exists for the good of the state is, of course, quite antithetical to our fundamental thesis that the role of the state is to ensure a maximum of individual freedom of choice and conduct."⁷⁸ The premise of most of the cases upholding a patient's right to refuse treatment is that "[n]o 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

76. 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

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

78. *In re Osborne*, 294 A.2d 372, 375 n.5 (D.C. 1972).

his own person, free from all restraint or interference of others"⁷⁹ Specifically, the patient must be free "to decide his own future regardless of the absence of a dim prognosis."⁸⁰

One element of the "preservation of life" interest is the desire to maintain the value of human life. However, several courts have questioned the validity of the "value of human life" interest when medical treatment decisions are involved. In *Saikewicz*, for example, the court reasoned that "[t]he value of life . . . is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice."⁸¹ The value of human life has at least these two dimensions, of prolonging life or permitting the patient to choose, and cannot clearly be said to be increased by denying the patient the right to choose the course of treatment merely because such a denial would prolong the patient's life. As a general matter, "[g]overnment tolerance of the choice to resist treatment reflects concern for individual self-determination, bodily integrity, and avoidance of suffering, rather than a depreciation of life's value. . . . [T]he asserted governmental interest in preserving the 'sanctity of life' appears too abstract and ephemeral."⁸²

The preservation of life interest also is asserted to prevent a patient from acting irrationally. The argument, in essence, is that "given any chance of meaningful life, no one wants to die," and anyone who says otherwise is acting irrationally.⁸³ That a decision be informed and considered is certainly an important concern. However, physicians and courts can ensure that decisions are reasoned.⁸⁴ Moreover, not everyone agrees about what constitutes a "meaningful" life. "For some, life is so dear that it is worth living even for a short time and with whatever deficits

79. *Botsford*, 141 U.S. at 251, quoted in *Rasmussen*, 741 P.2d at 682-83; *Conroy*, 98 N.J. at 346, 486 A.2d at 1221; *Brown*, 478 So. 2d at 1039; see also *Saikewicz*, 373 Mass. at 739, 370 N.E.2d at 426-27; *Satz*, 362 So. 2d at 163-64; *Severns*, 421 A.2d at 1342-43.

80. *Quackenbush*, 156 N.J. Super. at 290, 383 A.2d at 789.

81. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426; see also *Conroy*, 98 N.J. at 350, 486 A.2d at 1223.

82. *Cantor, Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 249-50 (1977).

83. *Morris*, *supra* note 35, at 920.

84. See *Farrell*, 108 N.J. at 346, 529 A.2d at 409 (the court finds that the patient made an informed and considered decision that "was not the result of a mere whim or casual decision."); *Yetter*, 62 Pa. D. & C.2d at 623-24 (finding the patient's decision to have been a reasoned judgment); but see *Gelfand*, *supra* note 5, at 717-58 (arguing that a rational choice to end a life is impossible to make since that choice is sensible only if the patient is in severe pain, but that condition makes such an important decision impossible to make).

As *Bouvia* indicates, and contrary to what *Gelfand* maintains, a patient may find that life is not worth living, despite not being in excruciating pain, because of the dehumanizing aspect of her treatment. See *supra* notes 60-65 and accompanying text.

in the quality of experience. For others, a short life without cognition or in pain and dependence is unendurable.⁸⁵ Therefore, courts and physicians should not use their own views as to what constitutes a "meaningful" life to conclude that a patient's reasoned decision is irrational.

Several courts have recognized the unacceptability of overseeing a patient's decisions regarding life-saving treatments and have rejected overruling such decisions because irrational. "The law protects [the patient's] right to make her own decision to accept or reject treatment, whether that decision is wise or unwise."⁸⁶ One commentator has even suggested that "[s]uicide may offer a rational exit out of an unendurable existence for some persons who are slowly dying from irreversible illnesses."⁸⁷

With the exception of artificial nutrition, withdrawing some forms of "necessary" treatment will not always result in certain death. In *Quinlan*, the patient lived for several years after the respirator was removed. In *Osborne*, the patient survived despite rejecting a blood transfusion.⁸⁸

At the same time, a non-terminal patient may still be unhealthy and likely to die shortly.⁸⁹ Considering the imprecision in prognoses, whether a patient is expected to die or to survive, "[i]t seems difficult to devise or to justify policies that restrict people's discretion to make appropriate decisions by allowing some choices only to 'terminally ill' patients or by denying them other choices."⁹⁰ Therefore, if the state interest in the preservation of life is not sufficient when the patient is terminal, it should not be sufficient for the suffering but non-terminal patient.

2. The Prevention of Suicide

The state interest in the prevention of suicide provides no stronger a basis for denying a patient the right to choose than does the state interest in the preservation of life. To the extent that the patient's conduct is not suicide, the two state interests are no different. The only questions, then, are whether the

85. Gostin, *supra* note 36, at 199; see also PRESIDENT'S COMMISSION, *supra* note 39, at 22-23 (discussing the existence of different views and underlying values concerning life and death).

86. *Candura*, 6 Mass. App. Ct. at 383, 376 N.E.2d at 1236; see also *Yetter*, 62 Pa. D. & C.2d at 623 ("[T]he court should not interfere even though the decision might be considered unwise, foolish or ridiculous.").

87. O'Brien, *Facilitating Euthanasia, Rational Suicide: Help Me Go Gentle Into that Good Night*, 31 ST. LOUIS U.L.J. 655, 656 (1987).

88. *Osborne*, 294 A.2d at 376 n.6.

89. See *Bartling*, 163 Cal. App. 3d at 189, 209 Cal. Rptr. at 221 (Bartling was not considered to be "terminal" but died prior to the court's decision).

90. PRESIDENT'S COMMISSION, *supra* note 39, at 25-26.

patient's decision can be considered suicide and, if so, whether the state interest in preventing suicide outweighs the patient's rights.

At least with respect to the withdrawal of nutrition, some argue that the patient's intent is to end his life, rather than to end invasive or burdensome treatment.⁹¹ The argument assumes that, in such a case, death is caused by starvation, induced by the patient's decision to have nutrition withdrawn, rather than by the underlying disease that caused the patient's condition.⁹² However, artificial feeding can itself be highly invasive, especially to a physically helpless but mentally competent patient.⁹³ Furthermore, the "cause" of death is open to question. Under the reasoning adopted by most courts considering this matter, death would be caused not by starvation but by natural causes. Following the withdrawal of nutrition, death would be from the patient's "inability to chew and swallow spontaneously and not the result of a self-inflicted injury."⁹⁴ Death would be the result of the disease that produced the condition and therefore by natural causes.⁹⁵ Although the patient would die as a result of the decision to refuse treatment, the "decision to allow nature to take its course is not equivalent to an election to commit suicide."⁹⁶

Even if the patient's decision were considered suicide, the state interest in preventing suicide is not significant in the case of a patient declining life-saving treatment. Rather than an irrational, impulsive attempt at self-destruction, the patient makes "a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in question and any state concern to prevent suicide."⁹⁷ Even if the

91. *Brophy*, 398 Mass. at 446-47, 497 N.E.2d at 642-43 (Lynch, J., dissenting in part) (considering the burdens of a gastrostomy tube to be minimal).

92. *Id.* at 447, 497 N.E.2d at 642-43 (Lynch, J., dissenting in part); see also *Von Holden v. Chapman*, 87 A.D.2d 66, 68, 450 N.Y.S.2d 623, 625 (1982) (observing that a prisoner does not have a constitutional right to commit suicide by starvation).

93. *Bowia*, 179 Cal. App. 3d at 1134, 225 Cal. Rptr. at 299 (acknowledging the lack of physical discomfort but arguing that the patient's "mental and emotional feelings are equally entitled to respect. She has been subjected to the forced intrusion of an artificial mechanism into her body against her will. She has a right to refuse increased dehumanizing aspects of her condition created by the insertion of a permanent tube through her nose and into her stomach.").

94. *Delio v. Westchester County Medical Center*, 516 N.Y.S.2d 677, 692 (N.Y. App. Div. 1987) (distinguishing *Von Holden*, where the patient was not suffering from any infirmities and could eat).

95. Besides the *Delio* court, several others have considered the withdrawal of nutrition to cause death by natural causes. See, e.g., *Conroy*, 98 N.J. at 351, 486 A.2d at 1224; *Brophy*, 398 Mass. at 439, 497 N.E.2d at 638.

96. *Bowia*, 179 Cal. App. 3d at 1144, 225 Cal. Rptr. at 306.

97. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; see also *Cantor, A Patient's Decision*, *supra* note 18, at 257 ("Most instances of refusal represent careful decisions to abide by religious or philosophical principles, and not rash attempts at self-destruction.").

patient may survive for an extended period with the treatment, the patient may still make a reasoned decision that a "natural" death would be preferable to the suffering.

3. *The Protection of Third Parties*

The third state interest is the protection of innocent third parties. The most significant group of innocent parties consists of the dependents of the patient. However, the dependents may not always be injured by the patient's death. In *Osborne*, the close family relationship that existed between the patient's children and his extended family, as well as the material provisions that the patient had made to provide for the care of the children, convinced the court that the patient had accommodated the state's interest in protecting innocent third parties.⁹⁸

In less exceptional cases, the interest of the dependents still may lie with allowing the patient to die. Considering the agony of watching a relative suffer, the family reasonably may prefer that the patient be allowed to die.⁹⁹ Furthermore, the dependents may be under less stress and may not be harmed if the patient dies sooner rather than later.¹⁰⁰

Not prolonging the inevitable death of the patient may also lessen the financial burden on the dependents. A suffering patient may be unable to earn much, if any, income, and the medical costs are likely to be substantial. Therefore, requiring the patient to live may impose not only an added emotional burden, but also a financial burden on the survivors. As a result, the interests of the dependents in overriding the patient's choice should outweigh the patient's interests only in exceptional circumstances.

The impact of the patient's choice on friends or non-dependent relatives should never trump the patient's right to decline life-saving treatment. Considering that individuals are permitted to divorce and take other actions that hurt others, the patient's personal decision should outweigh any emotional harm to these other, non-dependent individuals.¹⁰¹

The patient's decision to decline life-saving treatment also may have an impact on other patients who are situated near the patient. The patient who refuses treatment may harm other patients either by distracting the staff or by forcing the other patients to watch him die. If the patient's choice were denied,

98. *Osborne*, 294 A.2d at 374.

99. See, e.g., *In re Grant*, 109 Wash. 2d 545, 550, 747 P.2d 445, 448 (1987) (the patient's family all concurred in the decision to withhold future artificial life-support); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 9-10, 426 N.E.2d 809, 814 (Ohio Ct. Com. Pleas 1980) (all of the concerned third parties sought to have the patient's life support withdrawn).

100. *Farrell*, 108 N.J. at 352, 529 A.2d at 413.

101. See *Cantor, A Patient's Decision*, *supra* note 18, at 249-50.

however, nearby patients might have to observe even more suffering. Also, patients removed from certain forms of life-support could be moved either to other wings in the hospital or to their homes. In addition, the hospital staff may be able to concentrate more on those patients who desire treatment and thereby benefit them.¹⁰²

The court in *Requena* identified many of these considerations. For instance, the court observed that the hospital staff was under stress because the patient had refused basic care. The patient's death would have been painful both for the patient and for the staff-members who would have had to watch. An extended death, if the patient were not allowed to refuse care, also would have been painful.¹⁰³ Despite, or perhaps because of these stresses, the court observed that the decision regarding care was for the patient to make. Hospitals must deal with patients "in a way which fully respects their dignity, including as part of that dignity the right to choose one's treatment."¹⁰⁴

4. *The Protection of Medical Ethics*

The last state interest, protecting medical ethics, is implicated by "the effect that asking a physician to turn his back on a dying patient will have on the medical profession."¹⁰⁵ By refusing treatment, the patient will die and the physician will not be permitted to intervene.

The original distinction drawn by the *Quinlan* court, "between curing the ill and comforting and easing the dying,"¹⁰⁶ is not directly applicable here since the non-terminal, suffering patient is not dying. Nor are such patients in irreversible comas, as in *Quinlan* and other recent cases.¹⁰⁷

Nonetheless, medical ethics do not require physicians single-mindedly to preserve the lives of all patients who are neither terminal nor comatose. "[T]he drive to sustain life can conflict with another more fundamental (and arguably more venerable) objective of medicine—the relief of suffering."¹⁰⁸ The duty to prolong life is a recent one for medicine. Originally, medicine served three roles: eliminating the suffering of the sick, lessening the violence of diseases, and refusing to treat the sick who were "overmastered" by their diseases.¹⁰⁹ Respecting the wishes of

102. *See id.* at 250.

103. *Requena*, 213 N.J. Super. at 482-83, 517 A.2d at 890.

104. *Id.* at 485, 517 A.2d at 891.

105. *Morris*, *supra* note 35, at 917.

106. *Quinlan*, 70 N.J. at 47, 355 A.2d at 667.

107. *See, e.g., Brophy*, 398 Mass. at 439-40 & nn.37-38, 497 N.E.2d at 638 & nn.37-38; *Rasmussen*, 741 P.2d at 684.

108. PRESIDENT'S COMMISSION, *supra* note 39, at 15.

109. *Id.* at 15 n.2.

patients who have refused life-saving treatments is consistent with all of these roles.

Moreover, physicians exist for the benefit of their patients, and the best interests of every patient may not coincide with prolonging his or her life. The American Medical Association recognizes this conflict and allows the relief of suffering to take precedence over the duty to prolong life when the patient so chooses: "The social commitment of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have discretion to resolve the conflict."¹¹⁰

Under the principles of informed consent, furthermore, the physician's duty is only to give the patient the choice of which treatments to pursue. Of course, the physician must advise the patient of the risks of the various options the patient is considering. But the physician must honor the patient's choice, even when that choice conflicts with the advice or values of the medical profession as a whole.¹¹¹ The patient loses his right of informed consent whenever the physician rather than the patient makes a treatment decision.

By respecting the patient's choice, a physician never will be forced to *act* contrary to his ethical standards. The physician simply will be required not to interfere with the patient's choice.¹¹² If a hospital is unwilling to permit the necessary steps to stop treatment, a patient should be able to switch to another facility.¹¹³

Finally, whatever the physician's ethics may seem to require, they cannot outweigh the patient's right to choose his own treatment. The patient's right must be paramount to the doctor's obligation to provide care.¹¹⁴ Otherwise, the patient's right to self-

110. Opinions of the Judicial Council of the American Medical Association § 2.11 (1982), reprinted in *PRESIDENT'S COMMISSION*, *supra* note 39, at 300.

Section 2.11 deals specifically with terminally ill patients but the quoted paragraph demonstrates the American Medical Association's recognition of the conflict and the permissibility of letting a patient die when his life cannot be extended "under humane and comfortable conditions." See also Opinions of the Judicial Council of the American Medical Association § 2.10 (1982), reprinted in *PRESIDENT'S COMMISSION*, *supra* note 39, at 299 (recognizing the use of "quality of life" as a factor in determining when life supporting means ethically may be withheld or removed when a patient is "severely deteriorated").

111. *Conroy*, 98 N.J. at 352-53, 486 A.2d at 1225; see also *Yetter*, 62 Pa. D. & C.2d at 623 ("[T]he constitutional right of privacy includes the right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life . . ."); *Cantor*, *A Patient's Decision*, *supra* note 18, at 250-51.

112. See *PRESIDENT'S COMMISSION*, *supra* note 39, at 3 ("Health care professionals . . . may decline to provide a particular option because that choice would violate their conscience or professional judgment . . .").

113. See *Brophy*, 398 Mass. at 440-41, 497 N.E.2d at 639.

114. *Storar*, 52 N.Y.2d at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273, *cert. denied*, 454 U.S. 858 (1981).

determination is subject to the veto of physicians in one of the most important decisions an individual may ever make.

C. Are the Physicians Forced to Commit Murder?

Apart from the general state interests involved, a physician would not be justified in withdrawing or withholding treatment if that action constituted murder. In the leading case dealing with this problem, *Barber v. Superior Court*,¹¹⁵ the court found that the removal of life-support equipment was an omission for which the doctors could be held responsible only if they had a duty to act. However, since the patient had virtually no chance of recovering from his comatose state, the court held that the physicians involved had no duty to continue the "useless" therapy. "A physician has no duty to continue treatment once it has proved to be ineffective."¹¹⁶

Finding the conduct of the physician to be merely an "omission" and therefore different from taking positive steps to kill the patient is not a very satisfying basis on which to premise a murder acquittal. Although for some purposes the distinction may be useful, most commentators agree that it is neither logically nor morally sound.¹¹⁷ Whether considered an "act" or an "omission," the physician still alters the status quo so that the patient will die. Moreover, as a general matter this "omission" reasoning is faulty because even a withdrawal of treatment technically could constitute murder. Under the Model Penal Code, for instance, murder entails purposely or knowingly causing the death of another human being.¹¹⁸ When a physician, or anyone else, terminates a patient's life-support system, he usually will purposefully and knowingly cause the death of that patient.

An alternative to focusing on the act/omission distinction is to consider the patient to have died a natural death. Under this approach, no one actually "causes" the patient's death and consequently no one can be held responsible for it. This approach has been adopted by most courts that have considered the problem,

115. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

116. *Id.* at 1017, 195 Cal. Rptr. at 491.

117. See Koop & Grant, *supra* note 5, at 595 (arguing that omissions and active steps both are wrong); Gelfand, *supra* note 5, at 753-54 (arguing that the distinction is valuable only in terms of criminal law and that both are wrong); O'Brien, *supra* note 87, at 664 (arguing that both are reasonable and that "the act/omission distinction is illusory in moral and practical terms. Jurisprudentially, however, the line between active and passive death-inducing conduct has been scrupulously observed.").

See also *infra* notes 133-36 and accompanying text.

118. Lacey, *supra* note 47, at 453-54 (describing how the Model Penal Code treats active euthanasia as equivalent to murder).

starting with *Quinlan*: "[T]he ensuing death would not be homicide but rather expiration from existing natural causes."¹¹⁹

If the withdrawal of life-support systems from a terminal patient or the issuance of a "Do Not Resuscitate" order is considered to result in death by natural causes, then the withdrawal of life-support systems from a non-terminal patient should be considered to produce the same result. Although in the former cases the patients seem to be "closer" to death, the inadequacy of the terminal/non-terminal distinction suggests that to draw the line for labelling a death "natural" between these two types of patients, both of whom are on life-support systems, would be arbitrary. If a line must be drawn, the distinction should be between those patients who require life-support and those patients who do not. Any patient who requires life-support would, in the absence of treatment, die. Thus, if the withdrawal of life-support from a terminal patient or the decision not to resuscitate certain patients is considered to result in the natural death of those patients, then non-terminal patients, afflicted with what would otherwise be fatal diseases, also should be considered to have died natural deaths if they refuse life-saving treatments.

This "natural death" approach recognizes that the sustenance of patients by life-support systems is a new problem that did not exist until medical technology became capable of sustaining indefinitely, but not satisfactorily, a person's life. Although the approach is not completely accurate because the physician will have contributed to the patient's death, nevertheless the approach recognizes that the homicide laws probably were not intended to be used to force someone to "remain on the threshold of certain death suspended and sustained there by artificial life supports."¹²⁰ Indeed, like the homicide laws, laws respecting the choice of a patient not to be saved through overly intrusive or repugnant means are likewise embodiments of the right guarded most carefully at common law, the right of every individual to the possession and control of his own person, free from all restraint or interference by others.¹²¹

The state interests underlying laws prohibiting homicide are not applicable to the situation where a patient exercises his right to refuse medical treatment. These laws are based in part on protecting the "sanctity" or "value" of life.¹²² However, the state interest in protecting the value of life is not inconsistent with and certainly does not outweigh the patient's interest in self-deter-

119. *Quinlan*, 70 N.J. at 51, 355 A.2d at 670; *Colyer*, 99 Wash. 2d at 138, 660 P.2d at 751.

120. *Leach*, 68 Ohio Misc. at 6, 426 N.E.2d at 812.

121. See cases cited *supra* note 79.

122. MODEL PENAL CODE § 210.5 comment 5 (1980).

mination. Nor is the state interest in protecting potential victims significant when the "victim" is a patient who does not want protection.

Finally, if the right of a patient to refuse treatment is based on a constitutional right to privacy, then state criminal laws may not apply: "[T]he exercise of a constitutional right such as we have here found is protected from criminal prosecution. . . . The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right"¹²³

Balancing the strong self-determination interest of the patient against the questionable state interests of preserving life, preventing suicide, protecting innocent third parties, and protecting medical ethics, as well as the uncertain and inappropriate use of state homicide laws, indicates that, barring exceptional circumstances, any patient should be permitted to refuse life-sustaining treatment.

IV. THE SELF-DETERMINATION PRINCIPLES APPLIED TO EUTHANASIA

The same principle of self-determination that justifies permitting a suffering, non-terminal patient to reject life-sustaining treatment, when coupled with principles of humanity, suggests that at least a limited right to euthanasia should be recognized. Limiting this right to competent, suffering patients who will die soon without treatment should assuage the fears of many commentators that recognizing such a right will lead to involuntary euthanasia.

Under present law, active euthanasia probably would violate criminal laws against murder, even though a successful prosecution is unlikely.¹²⁴ Courts that have considered whether

123. *Quinlan*, 70 N.J. at 52, 355 A.2d at 670; *Colyer*, 99 Wash. 2d at 138, 660 P.2d at 751.

124. See *Lacewell*, *supra* note 47, at 453-54 (pointing out that euthanasia fits within the definition of murder, since it involves knowingly causing the death of another, the defense of consent does not apply when serious bodily injury is involved, and the defense of justification does not apply unless the conduct was required to avert a greater evil); *Colleston*, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304 (1977) (observing that a conviction or a prosecution as a result of a mercy-killing is unlikely in practice, and providing examples of acquittals in such cases and popular support for the doctors involved).

A defendant might argue that the mercy-killing was necessary to avert the greater evil that would result if the patient remained alive and suffering. However, even if a court agreed that the evil averted was greater than the evil caused, it might not accept the method used.

Additionally, a defendant might argue that even if euthanasia is murder, it is protected by the same constitutional right to privacy that permits the withdrawal of life-support systems. See Note, *The Right of the Terminally Ill to Die, with Assistance if Necessary*, 8 CRIM. JUST. J. 403, 423-24 (1986). However, a right to self-determination is not the same as that author's "right to die." The former means that others cannot interfere with the wishes of a patient, the latter would mean that a patient has a right to obtain the assistance of another.

euthanasia is illegal in the context of the withdrawal of life-support systems have stated that actual suicide or euthanasia is not being condoned or that it is illegal.¹²⁵ Regardless of whether euthanasia currently is illegal, a balancing of the interests involved suggests that in limited circumstances, euthanasia should be permitted.

The validity of euthanasia will depend on the circumstances. The argument for euthanasia is strongest in the case of a patient who either is expected to die soon or is connected to life-support systems whose removal will lead to a slow death.¹²⁶ Although there exists a danger that the patient's prognosis will be wrong, this danger exists in connection with all medical decisions. Using informed consent and the procedural safeguards discussed below will minimize the consequences of an incorrect prognosis.

Other actions that relieve the suffering of a patient but which do not constitute either euthanasia or the removal of life-support systems also should be permitted in appropriate circumstances. For instance, a suffering patient might be given greater than safe dosages of morphine to relieve pain, even though this procedure is likely to shorten the patient's life. In this case, administering an accepted medicine to relieve the patient's suffering is an acknowledged form of treatment. Many forms of medical treatment increase a patient's risk of death. Using an accepted medicine to relieve a patient's suffering is not qualitatively different.¹²⁷ In fact, many medical decisions involve a trade-off between the risk of death and the relief of suffering. Therefore, administering above-normal dosages of a pain-reliever which, like other acknowledged treatments, increases the risk of death in order to relieve suffering, should be permissible.¹²⁸

Most of the same considerations apply to euthanasia as to a patient refusing life-saving treatment. In the former case, however, the patient is seeking additional relief from suffering

125. See *Barber*, 147 Cal. App. 3d at 1012, 195 Cal. Rptr. at 487 (euthanasia "is neither justifiable nor excusable in California"); *Grant*, 109 Wash. 2d at 563, 747 P.2d at 454 ("we are not endorsing suicide or euthanasia").

126. If the patient will die very quickly after the removal of life-support systems, then euthanasia, obviously, is unnecessary. This is the situation of someone requiring artificial nutrition, who will die within a few weeks without the treatment, or someone in the final stages of a terminal disease who will die within a few months. Cf. *Saikewicz*, 373 Mass. at 733, 370 N.E.2d at 421 (the patient was dying of leukemia and could expect to live at most for several months without treatment). The patient presented here has, in essence, a "terminal condition." See *supra* note 3.

127. PRESIDENT'S COMMISSION, *supra* note 39, at 77-82.

128. See *id.* at 73 ("The Commission endorses allowing physicians and patients to select treatments known to risk death in order to relieve suffering as well as to pursue a return to health."); Capron, *supra* note 36, at 144 (arguing that pain relief should be available even if it shortens one's life).

and not merely the withdrawal of treatment. The patient's right of self-determination alone does not justify this additional step; that right does not extend beyond permitting the patient to refuse treatment, since it provides only a negative freedom against interference by others.¹²⁹ However, without euthanasia, the patient's option to refuse treatment may effectively be foreclosed. Presumably, the patient has refused treatment in order to avoid a prolonged life of suffering and frustration. Yet, the patient who has declined life-supporting treatment but is denied euthanasia may face weeks or months of intense physical or mental suffering. This extended suffering makes the decision to decline life-supporting treatment much more difficult. A limited right of euthanasia would enhance the patient's ability to exercise the right to refuse treatment and make that right more valuable.

The state interests related to the preservation of life and the protection of innocent third parties are no stronger in the context of euthanasia where the patient will die soon than in the context of the refusal of life-sustaining treatment, since the patient will die soon with or without the actual killing. The value of life still is protected in the context of active euthanasia because the patient is given a meaningful choice and because the consequences and motives of both active and passive euthanasia are the same. The interests of the patient are protected more by permitting the patient to die as he wishes than by keeping him alive, regardless of whether the patient dies from the withdrawal of treatment or from active euthanasia. In both cases, the patient dies sooner, according to his own will, and having suffered less, than if the physician had implemented all of the procedures available to keep the patient alive.

Two additional arguments favor permitting euthanasia in the case of the terminal patient. First, if a patient is allowed to die because treatment is withheld, or is dying of a terminal disease but is not on life-support,¹³⁰ then humane principles suggest that the patient's death should be made as comfortable as possible. A primary goal of medicine and society should be to minimize both physical and mental suffering. Euthanasia furthers that goal by minimizing the length of time during which a patient must suffer. Additionally, a patient is not allowed to die with his dignity intact if his refusal of treatment requires him subsequently to endure intense suffering. A patient's dignity is impaired both by re-

129. To provide an analogy: an individual's freedom to select the profession or education of his choice does not carry with it the right to obtain the financing to carry out that choice. If the individual cannot afford his choice, his right to self-determination is not hindered by others, only by his own lack of resources.

130. This second situation is also the result once the life-support of the non-terminal patient is removed.

quiring him to live against his will while dependent on others and by requiring him to die in an agonizing manner. Therefore, euthanasia is humane both in reducing suffering and in respecting the dignity of individuals.

As one of the justices in *Bouvia* stated:

This state and the medical profession instead of frustrating [the patient's] desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane.¹³¹

To carry out this goal, a lethal injection may be the preferred choice.¹³² If a lethal injection or similar method is not available, then the patient's ability to choose a death with dignity effectively may be foreclosed by the suffering endured after life-supporting treatment is withdrawn.

The second additional reason for permitting euthanasia in limited circumstances is that the distinction between an omission, or passive euthanasia, and an act, or active euthanasia, is not meaningful morally. Through either withholding treatment or actively providing a lethal injection, the physician initiates a course of events that leads to the patient's death.¹³³ The two are morally equivalent, since in both cases the physician alters the status quo to cause the patient's death.

Although active euthanasia may seem worse because it involves the physician actively causing the patient's death, active euthanasia also has positive symbolic elements. The act is done at the request of the patient and is done to minimize the suffering and indignities the patient must face. Euthanasia shows a willingness to respect the wishes of a suffering and unfortunate patient and to use medicine for the relief of suffering.

A complete withholding of treatment is slightly different than a withdrawal of treatment because in the first case the physician never takes any active steps. However, discerning a meaningful

131. *Bouvia*, 179 Cal. App. 3d at 1147, 225 Cal. Rptr. at 307 (Compton, J., concurring).

132. See generally O'Brien, *supra* note 87, at 664 (once the decision is made, "the easiest and most comfortable mode of death should be available.").

133. See Kuhse, *The Case for Active Voluntary Euthanasia*, 14 LAW, MED. & HEALTH CARE 145, 147 (1986) (argues for allowing both); O'Brien, *supra* note 87, at 664 (argues for allowing both); Koop & Grant, *supra* note 5, at 593-95 (argues against both); Gelfand, *supra* note 5, at 753 (argues against both).

Of course, by providing an injection, the patient no longer dies a "natural death," so murder laws apply. However, if passive and active euthanasia are equivalent morally, then permitting the former strengthens the argument for permitting the latter.

difference between a physician allowing a patient to die and a physician actively taking steps to hasten that death is especially difficult where the patient is suffering. Contrary to one goal of medicine, the patient may actually suffer more when allowed to die unaided by the physician than when aided. In either case, the patient dies when he does because of the action taken or not taken by the physician.¹³⁴

The difference between withholding and withdrawing treatment also has been rejected by courts.¹³⁵ Recognizing this difference could lead to inappropriate decision-making. If withholding treatment were permitted while withdrawing it were not, treatment either might be continued for longer than is appropriate or might not be started at all.¹³⁶

Active euthanasia clearly falls within laws prohibiting murder. However, as noted above, the state interests underlying the murder laws are implicated no more by limited acceptance of voluntary euthanasia than by recognizing a patient's right to decline life-saving medical treatment.¹³⁷

Euthanasia may also appear to pose other dangers. The state interest in protecting medical ethics and preserving the integrity of the medical profession could be jeopardized if physicians were thought to be actively seeking the death of patients. "To authorize active euthanasia would irreparably tarnish the public perception of medicine by associating the profession with activity purposely designed to cause death."¹³⁸ Proponents of this argument fear that some patients will not trust a physician to save them if he sometimes acts to kill other patients. However, euthanasia performed at the request of the patient should be no different than abortions and other controversial procedures that physicians per-

134. If the physician takes no steps, then the patient dies when the illness finally kills him. However, the physician could have delayed the death through treatment or hastened the death through a lethal injection. By not acting, therefore, the physician still has determined when the patient will die.

Besides causing more suffering, an omission seems to be equivalent to an act in that the intent in both cases is to cause the death of the patient and the motive is the same.

135. See, e.g., *Torres*, 357 N.W.2d at 339 ("The individual's right to refuse treatment also includes the right to order the disconnection of extraordinary life support systems."); PRESIDENT'S COMMISSION, *supra* note 39, at 61-62 (considering the distinction between withholding and withdrawing treatment to be improper).

Many of the decisions, such as *Quinlan*, involve the withdrawal of life-support and justify it by the right to decline treatment. This implies that the two are equivalent.

136. PRESIDENT'S COMMISSION, *supra* note 39, at 75.

137. See *supra* note 121 and accompanying text (discussing the application of the interests behind state murder laws to refusals of life-saving treatment).

138. Gostin, *supra* note 36, at 200; see also Capron, *supra* note 36, at 144 (believing that patients' trust in physicians would be shattered if they sometimes acted as "executioners").

form without tarnishing the medical profession. As long as euthanasia remains voluntary, patients have no more reason to fear being killed by their doctors than to fear that the doctors will perform surgery, an abortion, or any other medical procedure against their wishes. Patients might, instead, be comforted by knowing that a physician will not let them suffer and will respect their wishes.

No individual physician would be forced to perform euthanasia. As with other controversial procedures, a physician is free not to perform euthanasia if he considers it to be wrong. "[T]hose physicians who disapprove of [euthanasia] should not have to engage in it. But it does not follow that other doctors, who take a different view, should be forbidden, and so it does not follow that it would be wrong for the medical profession in general."¹³⁹ Some physicians already withdraw life-sustaining treatment and give "Do Not Resuscitate" orders for patients under some conditions. If taken in the case of a patient who desired the treatment, these actions would be equivalent to murdering the patient. Nevertheless, these procedures are accepted despite being designed purposely to cause or permit death.¹⁴⁰

Other arguments against permitting euthanasia in any form focus on the danger of abuse or mistake and the "slippery slope" from voluntary to involuntary euthanasia. The "abuse" argument focuses on the possibility that physicians will be able to kill patients against their will. The "mistake" argument focuses on the possibility that patients either will be misunderstood or will choose euthanasia thinking their situation is hopeless when a cure later will be discovered or their prognoses will prove to be incorrect.¹⁴¹

Dangers of mistake and abuse can be minimized by providing procedural protection for the patient in the form of a hearing and the possibility of a later criminal prosecution of physicians who disregard the wishes of the patient. A hearing would ensure that the patient is fully informed of the various options available and their likely consequences; that the decision is fully voluntary; that the patient's status has been confirmed, for instance by a second and independent examiner; and that the patient is aware of the likelihood of finding a cure and the possibility that a mistake has been made.¹⁴² The risk that a cure will be found or that a mis-

139. J. RACHELS, *THE END OF LIFE* 119 (1986).

140. For court approval of Do Not Resuscitate orders, see *Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978), permitting a physician to direct that resuscitation measures be withheld in the case of cardiac or respiratory arrest, without prior approval of a probate court.

141. See Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 377-78 (1984).

142. See *id.* at 378-82.

take has been made is no different than the risk involved in any other medical treatment decision made by a patient. Having been apprised of the relevant risks, the patient rather than the physician or the state should be able to make the determination as to what is best for the patient.¹⁴³ Euthanasia is proposed only for the patient who is expected to die in a relatively short amount of time, so the possibility of a cure appearing unexpectedly is very remote.

In order fully to benefit the patient, the hearing must be conducted and a resolution reached within a few days of the patient's request. The hearing could be held by a court or a hospital committee. The decision-maker need determine only that the elements of informed consent, voluntariness, and a terminal condition exist. This would be the decision-maker's only role. The patient would not have to demonstrate a "good reason" for choosing euthanasia.

For his consent to be informed, the patient must demonstrate that he has been informed of the available options and their consequences. The decision-maker can ensure that the patient understands and appreciates what he was told.

The patient would be presumed to be acting voluntarily in requesting euthanasia. Anyone could intervene to present evidence that the decision was not fully voluntary, but the burden would be on this intervenor to prove involuntariness, and delays would be permitted only if good cause were demonstrated. This would ensure that no one opposing the patient's decision could unjustifiably delay the proceedings and destroy the benefits of euthanasia. The decision-maker could interview the patient in private, if necessary, to ensure that the patient is not being improperly influenced by anyone else.

To prove that a patient either currently is terminal or will be terminal once life-support systems are removed, a physician not otherwise involved with the patient or associated with the patient's physician would be required to review the patient's record. This ensures that the patient's physician has not made a mistake and is not trying to deceive the patient.

No decision granting a patient's request should be appealable. If the patient is denied his request, he can try again. But, if people opposing the euthanasia could appeal, they could cause unacceptable delays. Also, since the determination is entirely factual, an appellate role, which is usually for review of legal issues, is inappropriate.

143. See Kuhse, *supra* note 133, at 147-48 (the procedural problems for active euthanasia are no different than the appropriate safeguards for passive euthanasia; in both situations, guidelines need to be established to determine who decides, how to prove prior consent, and to create adequate protection for patients).

In sum, the hearing protects the patient because it guarantees an opportunity to prevent the euthanasia if a mistake has been made or if the decision is either uninformed or involuntary. An elaborate procedure is undesirable because it would delay the euthanasia and defeat the purpose of providing euthanasia.

An elaborate procedure also is unnecessary because deterrence from abuse is provided by the possibility of a criminal prosecution for murder. A criminal prosecution could be brought if the state had probable cause to believe the euthanasia actually was murder. As a defense, the actor who performed the euthanasia would be permitted to claim that he performed voluntary euthanasia. He then would have to present evidence to a jury demonstrating informed consent, voluntariness, and a terminal condition, the same three factors required to be shown in the hearing.¹⁴⁴ The hearing would provide a record for the actor's defense but would not be considered conclusive in proving a legitimate mercy killing. The possibility of a criminal prosecution should deter the actor who would try to abuse the system and perform involuntary euthanasia.

Taken together, the procedural safeguards of a hearing and potential criminal liability counter the fears of mistake or abuse. The remaining concern, the "slippery slope" argument, while it seems more compelling, ignores the basis in self-determination for the right asserted by the patient. This self-determination basis can ensure that involuntary euthanasia does not occur. The "slippery slope" objection is based on the fear that the acceptance of any form of euthanasia creates "an exception to the homicide law based on subjective factors that will not submit to precise definition or limitation."¹⁴⁵ The inevitable result, claim the objectors, will be involuntary euthanasia and quality-of-life determinations being made for others to justify killing. Once killing is made acceptable, the state will be able to eliminate "undesirable" people too easily, because no clear line will distinguish those who legitimately can or cannot be killed.¹⁴⁶

144. See RACHELS, *supra* note 139, at 185 (suggesting the use of a "mercy-killing" defense to a murder charge, without the need for an initial hearing, because a hearing would be too time-consuming; the defense would require showing that the victim was competent when he requested death "and that the victim was suffering from a painful terminal illness").

As Rachels points out, this defense is what occurs in practice already, where juries often acquit defendants who have carried out a mercy-killing.
Id. at 186-87.

145. Koop & Grant, *supra* note 5, at 595.

146. *Id.* at 589-90 (fearing that acceptance of passive euthanasia will lead to the intentional killing "of those whose lives are considered of insufficient value to maintain," and pointing to the Nazi atrocities as erupting from an initial acceptance of euthanasia); Gelfand, *supra* note 5, at 763-66 (arguing that the preservation of life ensures that quality of life determinations for others, involuntary euthanasia, and the abuses of World War II do not occur).

For this parade of horrors to occur, so great an abuse of the euthanasia right would be required that its mere suggestion is fantastic. A line can be drawn. Euthanasia is justified by the patient's right to self-determination coupled with a desire to minimize the suffering of those who exercise that right and decline treatment. Euthanasia allows those patients who would otherwise be prevented by medical problems, to exercise fully their right of self-determination.¹⁴⁷

Since the basis for permitting euthanasia is the patient's right of self-determination, euthanasia dictated by the state or a physician would violate that right. The state would violate the core of the individual's right to self-determination and bodily integrity if it were to determine that an individual's quality of life was not sufficient to permit that individual to live. The individual's interest in bodily integrity is violated more by a "treatment" that kills him than by treatment designed to help him. The logic that places decisions to refuse treatment at the heart of the individual's right to self-determination places the individual's right not to be killed against his will in the same position. In either case, the individual rather than the state or the physician should decide the course of his treatment.

A different situation is presented by the non-terminal patient who, although suffering greatly, could live for years even if treatment were withdrawn.¹⁴⁸ In this case, since the patient is not in immediate danger of dying, the state's interest in the preservation of life is much stronger. In addition, the patient's interest in self-determination is less decisive because the physician is doing nothing to interfere with the patient's life. Also, the possibility that a non-terminal patient who has opted for euthanasia might have changed his mind several months later—less of a worry if the patient has only a few months to live—encourages caution.

Nonetheless, the non-terminal patient is in a very unfortunate position. His reason for choosing euthanasia is no different from that of a terminal patient suffering from the same disease who

Rachels, however, disputes the validity of the Nazi analogy, arguing that those killings did not start with compassionate motives, were never done to benefit suffering victims, never included the permission of the victims, and from the beginning were involuntary. Rather, the Nazis used the term "euthanasia" merely to mask their murderous, racist policies. No slippery slope was involved since the killings were involuntary from the beginning. RACHELS, *supra* note 139, at 177-78.

147. Those people who are not physically disabled do not need a right to euthanasia, since they always have the option to commit suicide if their suffering becomes too great. In practice, the state will not be able to stop a non-disabled individual determined to end his life. See Cantor, *A Patient's Decision*, *supra* note 18, at 256.

148. This could be someone with incurable cancer, who either could live for several years or longer, or is otherwise deteriorating physically but whose death is not expected for a long time.

happens also to require some independent life-preserving treatment. But since the non-terminal patient not on life-support is not receiving some "heroic treatment which can be withheld," his only chance for relief from suffering may be active euthanasia in the form of a lethal injection.¹⁴⁹

Because of the harm possible from permitting euthanasia to become too widespread and because of the shifting balance between the interests of the patient and those of the state, euthanasia should be allowed only for certain patients: those who are considered "terminal," either because they will die in a relatively short time regardless of whether they receive treatments or because they will die in a relatively short time only by refusing treatments. This definition of "terminal" may not always coincide with the medically accepted definition.

The non-terminal patient is protected in two ways. First, the non-terminal patient may receive whatever amounts of pain-reliever are needed to relieve his physical suffering, even if the necessary dosage shortens his life.¹⁵⁰ Second, since no one will be able to stop a patient determined to commit suicide, the danger of prolonged, undesired suffering for the non-terminal patient is slim.¹⁵¹ With this limitation, the patient's right of self-determination will be protected and the infringement of state interests kept to a minimum. Although the distinction between a "terminal" and a "non-terminal" patient is imprecise, such imprecision does not pose a danger of abuse in the form of involuntary euthanasia as long as the procedural safeguards of a hearing and potential criminal prosecution, suggested above, are followed.

CONCLUSION

The right of a patient to refuse undesired treatments should be recognized even when refusing the treatment would lead to the death of the patient. A limited right to euthanasia as an extension of the right to refuse treatment will allow patients fully to exercise and to enjoy their right to self-determination. Some commentators argue that no patient can be allowed to die through active or passive euthanasia, because "no just society can risk the profound evil of devaluing the life of any human being, no matter

149. O'Brien, *supra* note 87, at 663.

150. See Capron, *supra* note 36, at 144 (favoring the availability of pain relief, even if it shortens the patient's life, although opposing active euthanasia); PRESIDENT'S COMMISSION, *supra* note 39, at 73 (the same).

151. Few, if any, situations are likely to occur where a physically disabled individual is neither terminal nor on some life-support. In those rare instances, euthanasia also may be justified if the patient desires it.

how profoundly that life may be impaired."¹⁵² However, as the Massachusetts Supreme Judicial Court observed, "[t]he value of life . . . is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice."¹⁵³ A limited right of euthanasia protects the right of choice, and therefore the value of life, by permitting patients to choose a painless and dignified death rather than a slow, agonizing death or a long existence attached to and dependent upon intrusive and dehumanizing machines.

152. Koop & Grant, *supra* note 5, at 634.

153. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426.