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# STUDIES IN LAW AND MEDICINE

**Prolonging Life and Withdrawing  
Treatment: Legal Issues**

by  
**Dennis J. Horan  
Edward R. Grant**

*An Educational Publication of  
Americans United for Life, Inc.*



**No. 15**

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**Law and Medicine Series**

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## Prolonging Life and Withdrawing Treatment: Legal Issues

by Dennis J. Horan\*  
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### Introduction

The search for an appropriate scheme of laws to govern medical practice is always difficult, but never more so than in the areas of euthanasia, the "right to die", and the termination of medical treatment. An "appropriate" legal scheme would be one that protects the interests of individuals and society, while allowing physicians sufficient freedom to practice their profession. Rapid changes in medical ethics have compounded the problems faced by courts and legislatures as they address these issues. Adding to the confusion is the multitude of interests that must be considered in the question of when medical treatment may be terminated: those of the patient, the family, the state, the physician and the medical institution.

The proposed solutions to these problems too often focus on one interest, at the expense of ignoring others. For example, some commentators emphasize that the interests of the family should be paramount, urging that the broadest possible powers to terminate medical treatment, consistent with the law, should be granted to the family.<sup>1</sup> The danger of such an approach is illustrated in reports of medical neglect and starvation of handicapped newborn infants, "in accordance with the parents' wishes".<sup>2</sup>

These cases indicate that the family may be incapable of voicing or protecting the interest that society might have in the preservation of life for its handicapped, aged or infirm members.<sup>3</sup> Therefore, a significant difficulty the law faces in resolving the termination of treatment problem is the balancing of the competing social and personal interests which converge in this issue. This is particularly true when determining the rights, duties and obligations surrounding the incompetent and children.

Despite these many hurdles, judges and legislators who have grappled with the problem have reached a rough consensus on the legal principles to be applied in termination of treatment cases. It is not always easy to discern this consensus among the court opinions and legislation of recent years, but a careful investigation reveals that it is nevertheless there. To understand how this consensus has come about, it will be necessary to discuss briefly the chief legal doctrines that come into play when a decision to continue or to discontinue medical treatment must be made. We then will analyze how these doctrines were applied in two termination of treatment decisions in the courts of New York, and follow with a discussion of "living will" or "natural death" legislation that has been passed in many states. Finally, we will take a look at some of the unanswered question in this area, including the problems arising in the case of handicapped newborns.

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## 1.) Basic Legal Doctrines Concerning the Withdrawal of Medical Treatment

**The Right to Refuse Treatment** — Under the common law, a competent adult, as part of the right of self-determination, has a right to refuse medical treatment.<sup>4</sup> This is one reason why an adult patient must give informed consent to medical treatment, such as surgery, and why, in the case of minor children or incompetent persons, a parent or guardian must give consent.

The right of an adult to refuse medical treatment extends even to situations where such refusal will lead to the death of the patient. In *Satz v. Perlmuter*,<sup>5</sup> the Florida Supreme Court held that a 73-year-old patient, mortally ill from amyotrophic lateral sclerosis, could knowingly direct his removal from a respirator, even though it was certain that death would follow in an hour. The court found that a patient has a right to refuse life-preserving medical treatment especially when such treatment is extraordinary and the patient suffers from a terminal illness.

The right to refuse treatment, however, is not absolute. In many instances where members of religious sects have opposed the receipt of blood transfusions, claiming that this medical procedure violates their religious principles, the courts have nevertheless ordered the transfusions to be administered.<sup>6</sup> The rationale of these decisions is that the *state interest* in preserving the life of the individual outweighs the right that the individual has to refuse life-saving medical treatment, even on grounds of religious belief. In the case of children, the courts maintain that a parent may not withhold from his child emergency treatment that is necessary to save the life of the child. In the case of adults, courts have held that the state has an additional interest in protecting the interests of third parties, for instance, children who would be orphaned if their parents are not given emergency life-saving treatment.<sup>7</sup>

**The Constitutional Right of Privacy** — In the case of Karen Quinlan, the Supreme Court of New Jersey held that a person who is terminally ill has a constitutional right of privacy that includes the right to refuse extraordinary medical care.<sup>8</sup> The court also said that this constitutional right must be balanced against the same state interests that are to be considered with the common law right to refuse medical treatment, especially the interest in preserving life.<sup>9</sup>

The court held that, in the *Quinlan* case, the state interest in preserving life had diminished because of Karen's chronic vegetative, comatose condition.<sup>10</sup> It judged (wrongly as it turned out) that she was terminally ill, and that the respirator which assisted her breathing was merely prolonging the process of dying. Thus, the court held that Karen would be within her rights to refuse further respirator treatment, and since she was incompetent to exercise these rights, that her father, as guardian, could consent to a decision to remove the respirator. The court, however, did not give Mr. Quinlan an absolute right to direct the course of his daughter's treatment, only the right to choose which physician would be responsible for that treatment.<sup>11</sup> It was assured therefore that the ultimate decision in this case would be a medical decision consented to by the patient's parents.

When medical practitioners withdrew the respirator from Karen, they

used a weaning process that enabled her to develop a capacity to breathe on her own. She has thus survived for nearly seven years, without mechanical respiratory assistance, but still in a completely bedridden, comatose condition.

The New Jersey Supreme Court did not clarify exactly why it was necessary to develop a constitutional right to refuse treatment in addition to the well-established common-law right. The handful of decisions which have adopted the doctrine of the *Quinlan* case also have failed to do so. It is significant, however, that all of these cases involved patients who were incompetent due to a chronic comatose condition or a mental disability. The constitutional right to refuse treatment appears to have been adopted to meet the special problems presented by these cases, involving persons who cannot communicate their consent or refusal of medical treatment. Standing alone, however, the right to privacy does not solve the problem of treatment termination for a comatose person who is equally as unable to exercise his constitutional right of privacy as he is to exercise his common law right of self-determination. Courts have employed the doctrine of "substituted judgment" to avoid this problem.

## 2.) Substituted Judgment and Judicial Review of Treatment Decisions

The case of Joseph Saikewicz<sup>12</sup> involves a 67-year-old man with an I.Q. of 10 who had been institutionalized in Massachusetts state hospitals throughout his life. Mr. Saikewicz was afflicted with acute myeloblastic leukemia for which the usual treatment is chemotherapy. The state hospital officials in charge of his case petitioned the courts to appoint a guardian for Mr. Saikewicz. The guardian and the attending physicians recommended against the use of chemotherapy, and the Supreme Judicial Court of Massachusetts ultimately affirmed this decision.

The Massachusetts court agreed with the *Quinlan* decision that the constitutional right to privacy is implicated in cases of this kind.<sup>13</sup> Finding that this right to refuse treatment must be available to incompetent as well as to competent patients, the court held that the judgment of a court-appointed guardian could be substituted for that of the patient. In making this "substituted judgment," the guardian is to consider the best interests of the patient and, as nearly as possible, is to make the same decision that the incompetent patient would have made if he or she had been able to decide upon a course of treatment.<sup>14</sup> The *Quinlan* court also had adopted this approach, concluding in support of its decision that if Karen were miraculously lucid for a moment, she would ask to be removed from her respirator.<sup>15</sup>

The *Quinlan* and *Saikewicz* decisions diverge, however, on the issue of whether court approval is necessary for a decision to withdraw treatment. The New Jersey court said that the decision to remove Karen's respirator could be approved by a hospital "ethics committee," composed of physicians, administrators, clergy and lay persons from the community.<sup>16</sup> The Massachusetts court, however, criticized *Quinlan* for allowing family and physicians to make such decisions without court authority, and explicitly stated that court approval must be sought.<sup>17</sup>

A year later, in the *Matter of Earle Spring*, the same court explained:

[I]f the judge in such a case [is] not persuaded that the incompetent individual's choice, as determined by the substituted judgment standard, would have been to forego potentially life-prolonging treatment, or if the interest of the state required it, the treatment [is] to be ordered.....

[W]e disapprove shifting of the ultimate decision-making responsibility away from the duly-established courts of proper jurisdiction.<sup>18</sup>

This holding has been strongly criticized as substituting the judgment of courts for medical judgments that may be made only by a physician.<sup>19</sup> Apparently sensitive to this criticism, the Massachusetts court stated that physicians will not be liable automatically in a lawsuit if they withdraw treatment without judicial approval. Neither will they be immunized automatically from such liability if they obtain court approval, but employ their medical efforts in a negligent fashion.<sup>20</sup>

These remarks emphasize the fact that in treating a terminally-ill patient, a physician remains bound by the general standards of law that govern the practice of medicine. The new principles that were enunciated in decisions such as *Quinlan* and *Saikewicz*, therefore, represent only some of the standards of care to which the law may hold a physician.

**When Treatment May and May Not Be Withdrawn —** Courts have generally held that treatment may be withdrawn only from patients who are in a severe condition of terminal illness. The Massachusetts Supreme Court in *Saikewicz* limited the application of the rule allowing treatment to be withdrawn to those cases in which the patient has (1) an incurable and terminal illness, for which (2) there exists no life-saving or life-prolonging treatment, or (3) where the treatment, if available, would only result in a brief and uncertain delay in the natural death process.<sup>21</sup> The court found that these criteria were met in the case of Joseph Saikewicz, since it was certain there that he was dying of leukemia. The court placed special emphasis on the third criterion, noting that the initiation of chemotherapy could bring about a temporary remission of the illness, lasting several months to one year. Despite its potential for prolonging life, however, chemotherapy also would bring considerable discomfort to the patient. Taking into account the patient's total inability to comprehend or to cooperate in this difficult course of treatment, the court affirmed the decision that the treatment could be withheld.

The Massachusetts Supreme Court followed its guidelines of *Saikewicz* in the *Matter of Earle Spring*. That case involved a 77-year-old man who suffered from end-stage kidney disease and chronic organic brain syndrome (senility).<sup>22</sup> The kidney disease required a thrice-weekly hemodialysis treatment. Although removal from dialysis would be fatal, the state supreme court held that the patient had common law and constitutional rights to resist the nonconsensual invasion of his body. Further, it found that this right may be exercised by the substituted judgment of a guardian.<sup>23</sup> The court repeatedly characterized Mr. Spring's disease as incurably fatal and termed the hemodialysis life-prolonging, rather than life-saving. Finding that "there

was no prospect of cure or even a recovery of competence," the court held that the Saikewicz criteria had been met and that, with court approval, treatment could be withdrawn.<sup>24</sup>

A common form of treatment withdrawal in hospitals is the issuance of the order "do not resuscitate." Under a "DNR order," measures such as cardiopulmonary resuscitation, intubation, and mechanical ventilation will not be used if a patient suffers a cardiac or a respiratory arrest.

A Massachusetts appellate court found such a DNR order to be appropriate in the case of *Shirley Dinnerstein*. A 67-year-old with Alzheimer's disease, this woman also had suffered a stroke; she was in an essentially vegetative state, immobile and speechless. The opinion of the court emphasized that the patient's prognosis was hopeless and that death appeared imminent.<sup>26</sup> Resuscitative measures for Mrs. Dinnerstein offered no real hope of relief or remission from the fatal illness. The court held that in such a case, where the issue is what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient, the decision is to be made not by the judiciary, but rather by the attending physician.<sup>27</sup> Thus, according to this opinion, a DNR order may be appropriate where death is imminent.

In a recent case, *Custody of a Minor*,<sup>28</sup> a Massachusetts appellate court upheld a similar DNR order for an infant who had been born with severe handicaps. A potentially important development, this decision addressed the issue of DNRs with specific regard to children. In support of its finding, the court cited both *Dinnerstein* and the "substituted judgment" standard of *Saikewicz*. It found that the parents had acted properly by exercising judgment on behalf of their child and approving the DNR order.

A Minnesota case illustrates that DNR orders, however common, will meet resistance in some instances.<sup>29</sup> Sharon Siebert, a middle-aged woman, suffered severe complications during brain surgery that resulted in brain damage and near-total paralysis. After several years, a DNR order was given; no resuscitative measures were to be undertaken, even in the event of choking (to which Mrs. Siebert was especially susceptible). A friend of Mrs. Siebert challenged the DNR order, arguing that since the patient was not terminally ill, life-support measures could not be withheld. A state district court agreed.

Understandably, the consequence of these judicial opinions is often confusion. In *Severns v. Wilmington Medical Center*,<sup>30</sup> for example, the Supreme Court of Delaware included in its opinion a long series of questions. It queried, for example, "what is a life-sustaining system for a person who has been comatose for many months?"<sup>31</sup> and pondered whether food and medicines are to be considered "life-sustaining systems." The court ruled in *Severns* that the decision to withdraw a respirator from a woman who had been critically injured in an automobile accident and was in a chronic comatose condition should be guided by the principles that were set forth in *Quinlan* and *Saikewicz*. The court's "free inquiry," however, may have implied a concern that approved termination of treatment was tantamount to legalized mercy-killing, an active administering of the proximate cause of death.

Thus, the *Severns* case, while not deciding any of the factual issues involved, leaves one with the disquieting impression that the comatose patient



may find himself on a "slippery slope," as the courts subtly push toward the legalization of euthanasia.

This is the ultimate consequence of the failure to distinguish the truly terminal case from the non-terminal one in the application of the legal principles for allowing the withdrawal of medical care. Once termination of treatment is allowed by the courts in non-terminal cases, and for other than medical reasons, the door is open to legalized euthanasia. Euthanasia may be defined as any action, passive or active, taken with the intent of hastening or causing death.

Perhaps this development is illustrated best by the recent case of "Infant Doe," who was born at Bloomington Hospital (Bloomington, Indiana) in April, 1982.<sup>32</sup> Physicians diagnosed Infant Doe as being afflicted with Down's Syndrome, with the additional complication of an esophageal fistula that made normal food ingestion impossible. Despite the recommendation of the child's pediatrician that life-saving corrective surgery should be performed immediately on the fistula, the parents refused their consent. They were supported in this decision by their obstetrician and the hospital. Deprived also of intravenous nourishment and hydration, the baby died six days later.

A Monroe County Circuit Court judge convened a hearing at the hospital on the second day of the child's life, and held that the decisions to withhold surgery and nourishment were a proper exercise of parental authority and medical judgment. The court was asked several times to reconsider this finding by the county prosecutor, who brought an action under the state child abuse statutes, and by private parties who sought to adopt the child and order the life-saving surgery. An appeal was pressed to the Indiana Supreme Court, which rejected it in a 3-1 decision.

Infant Doe was not born dying and his was not a case of terminal illness. Only the decision to withhold ordinary care made Infant Doe's case hopeless. Intravenous food and water plus a routine surgical procedure were virtually certain to ameliorate his life-threatening condition. The principles of the *Quinlan* and *Saikewicz* decisions do not support the denial of the surgery. More obviously, they do not support the denial of simple sustenance. Such conduct is plainly homicidal.

Withholding treatment in this case caused the infant's death just as surely as would the injection of poison into his veins. And unlike *Quinlan* and *Saikewicz*, no diagnosed lethal condition (besides unnecessary dehydration and malnutrition) imminently threatened the patient's life. *Infant Doe* begins to illustrate the dangers presented when the principles for withholding medical treatment to the incompetent are not limited to the truly terminal situation.

Other courts have made the proper distinctions and have ordered beneficial treatment for infants in situations similar to that of Infant Doe. In the *Baby Houle*<sup>33</sup> case, a Maine court was faced with a situation virtually identical to that of Infant Doe. It appointed a guardian to give consent for the corrective surgery against the wishes of the parents. In the *Cicero*<sup>34</sup> case, a New York court ordered corrective surgery for an infant who was born with spina bifida. Pressure from Federal authorities recently brought about a similar decision, settled out of court, in the case of a spina bifida infant born in Robin-

son, Illinois. Finally, in the famous *Chad Green* case,<sup>35</sup> the Supreme Court of Massachusetts affirmed a lower court decision that took custody of a 20-month-old child away from his parents. The child suffered from leukemia, and his parents had refused to consent to the prescribed treatment, chemotherapy. In all cases, the treatment that was ordered was both life-prolonging and life-saving. Under these circumstances, the state's interest in protecting the life of the child outweighs the parents' right to direct medical treatment.

### 3.) Applying the Legal Standards: The Cases of Brother Fox and John Storar

One means of synthesizing the material discussed thus far is to examine the ways in which the aforementioned legal principles have been applied in individual cases. Two that are useful for such a study are those of Brother Joseph Charles Fox and John Storar, both of which took place in New York.<sup>36</sup>

Joseph Charles Fox was an 83-year-old religious brother in the Society of Mary, residing in retirement on Long Island. During a routine operation in October, 1979 he suffered a massive cardiopulmonary arrest. Though resuscitated by a mechanical ventilator, Brother Fox had suffered a cessation of oxygen flow to the brain, resulting in profound, irreversible brain damage.<sup>37</sup> He remained in a coma for four months, and, despite the continued assistance of the respirator, died of congestive heart failure on January 24, 1980.<sup>38</sup>

While Brother Fox remained alive on the respirator, his religious superiors, led by Father Philip Eichner, asked the hospital and the attending physician to authorize removal of the respirator, allowing Brother Fox to die without "extraordinary" medical treatment. This request was denied, so Father Eichner petitioned a county court to be appointed the guardian of Brother Fox. He requested the specific power to direct the withdrawal of the respirator. At the court hearing, Father Eichner offered evidence of prior statements made by Brother Fox indicating that he did not wish extraordinary means to be used to sustain his life should he ever fall into an irreversibly comatose condition. Ironically, Brother Fox had made these statements during a discussion of Karen Quinlan's case.<sup>39</sup>

The trial court ruled that these statements of Brother Fox should be construed as an exercise of his common law right of self-determination, and therefore should be honored by his physicians.<sup>40</sup> Concluding from the medical evidence that there was no hope for recovery or even significant improvement in Brother Fox's condition, and that the respirator could only extend the process of dying, the court ruled that the interests in the preservation of life would not be compromised by the withdrawal of the respirator. The trial court found it unnecessary and unwise to base its decision on the constitutional right to privacy.<sup>41</sup>

The district attorney of Nassau County appealed to the Appellate Division of the Nassau County Supreme Court. The appellate court affirmed the decision, but issued a very different type of opinion, which relied primarily on the *Quinlan* principle of the constitutional right to privacy.<sup>42</sup> The court ruled

that the right to die with dignity, without continued use of mechanical life-support systems, was protected by the right of privacy. Furthermore, the court held that the state interest in the preservation of life does not extend to a patient in the condition of Brother Fox, since there is virtually no life left to protect. Finally, the court said that it is not necessary that a patient should have expressed the desire to have treatment withheld; that is, even if Brother Fox had not made the statements that were so heavily relied upon by the trial court, his constitutional right to die with dignity could have been exercised by the substituted judgment of a court-appointed guardian.<sup>43</sup>

The Appellate Division's opinion went further than any earlier decision in defining a specific "right to die."<sup>44</sup> Previously, as in the *Quinlan* and *Saikewicz* cases, the courts spoke in terms of a right to refuse treatment, even when such treatment is necessary to sustain life. The difference between this concept and the "right to die" is more than semantic, because, in the incremental dynamic of development that is characteristic of the law, this seemingly slight distinction paves the way for courts to fashion a more positive right to die, by more direct, active means.

Such a development could bring about the legalization of euthanasia, or "mercy-killing," which is currently forbidden throughout the United States. If such a "right to die" is found to exist under the U.S. Constitution, then we will be faced with the paradox of a Constitution that includes a right to die as well as a right to life. Further, if the power over exercise of these rights in the case of incompetent persons is given to parents and guardians under the principle of substituted judgment, the potential for abuse will be enormous. This is illustrated painfully well by the now famous *Infant Doe* case.<sup>45</sup>

In recognition of this potential for abuse, the Appellate Division sided with the Massachusetts courts and required that any decision to withhold life-preserving treatment from a terminally-ill patient must be sanctioned in a court of law.<sup>46</sup> The court also limited the application of the principle of substituted judgment over the right to die to those cases in which a patient is in the gravest physical condition: "The necessary medical criteria for the activation of the patient's right are self-apparent", said the court. [H]e must be terminally ill; he must be in a vegetative coma characterized by the physician as 'permanent', 'chronic' or 'irreversible'; he must lack cognitive brain function; and the probability of his ever regaining cognitive brain function must be extremely remote. The State's interest in protecting the sanctity of life will tolerate no less stringent medical standard than this."<sup>47</sup>

Thus, what the Appellate Division seemed to give with one hand in creating a "right to die," it took away with the other by severely limiting the application of that right. It decided, though, that for the case of Brother Fox, the necessary criteria had been met, and thus judicial approval for the removal of the respirator was affirmed. Although Brother Fox had died by the time of the decision, the court indicated that it intended that these standards should be applied widely. Concerned about those wider implications, the district attorney lodged an appeal to the Court of Appeals, the state's highest bench.

In the Court of Appeals, the case of Brother Fox was joined with that of John Storar, a 56-year-old adult with a mental age of less than two years, who had been institutionalized throughout his life in a state hospital near Rochester.<sup>48</sup> Storar suffered from terminal cancer and was receiving fre-

quent transfusions to compensate for blood loss due to internal bleeding. His mother, who also was his court-appointed guardian, at first consented to the transfusions, then asked that they be discontinued out of concern for her son's comfort.<sup>49</sup>

The hospital petitioned the Monroe County court for authority to continue the transfusions over the objection of Mrs. Storar. At the hearing on the petition, hospital staff members testified that Storar would become lethargic and unable to perform his routine daily activities without the transfusions, but that he would die despite the continued transfusions within a matter of months. Several medical experts testified in support of Mrs. Storar that at this stage of disease, blood transfusion might only serve to prolong suffering and thus may be discontinued.<sup>50</sup>

The court held, following the opinion of the Appellate Division in the Brother Fox case, that John Storar had a constitutional right to refuse blood transfusions which could be exercised on his behalf by his mother. Mrs. Storar, the court explained, was the best person to determine what John would decide if he were competent to make that decision.<sup>51</sup> The Appellate Division of the Monroe County court summarily affirmed, and the case was brought to the Court of Appeals.<sup>52</sup>

The Court of Appeals resolved both the cases of Brother Fox and John Storar without employing the constitutional right to privacy that had been invoked by the lower courts, and adopted in New Jersey and Massachusetts. In a brief opinion, the court stated that it would not reach the question of applying the constitutional right of privacy to the case of Brother Fox because the relief granted to Father Eichner, the priest who brought the original suit, "is adequately supported by common law principles." The court thus dismissed the substance of the opinion of the Appellate Division and returned to the common-law right of self-determination that had been used by the trial court.

In the case of John Storar, the Court of Appeals rejected as "unrealistic" any attempt to determine whether the patient, if he were competent, would want the potentially life-prolonging blood transfusions discontinued. Storar, the court stated, was never competent at any time in his life, and "totally incapable of understanding or making a reasoned decision about medical treatment.... Mentally, John Storar was an infant and that is the only realistic way to assess his right in this litigation.... This case bears only superficial similarities to [*Brother Fox*] and the determination must proceed from different principles."<sup>53</sup>

Because John Storar was an infant, the court ruled that his mother could consent to his medical treatment, but could not deprive him of life-saving treatment. Even if a decision to withhold treatment is well-intentioned, or motivated by religious beliefs, "it must yield to the State's interests, as *parens patriae*, in protecting the health and welfare of the child."<sup>54</sup> This follows from the principle, discussed above, under which courts will not allow parents to deny blood transfusions that are necessary to save a child's life.

John Storar, the court recognized, eventually would die of cancer. Without the blood transfusions, however, he might die sooner, and certainly, his physical condition would deteriorate more rapidly. The court said:

[T]he transfusions were analogous to food — they would not cure the



cancer, but they could eliminate the risk of death from another treatable cause. Of course, John Storar did not like them, as one might expect of one with an infant's mentality. But the evidence convincingly shows that the transfusions did not involve excessive pain and that without them his mental and physical abilities would not be maintained at the usual level. With the transfusions, on the other hand, he was essentially the same as he was before except of course he had a fatal illness which would ultimately claim his life...

These two case histories demonstrate the variety of legal doctrines that may be applied to the same set of facts by the courts. The problems posed by such conflict are not severe, and the approach followed by the Court of Appeals may become a model for addressing such cases in the future. The benefit of their opinion is its demonstration that principles of the common law can be used to resolve difficult medico-legal questions rather cleanly, without the intervention of the constitutional law and the complexity that is inherent in applying constitutional law doctrines.

This relative simplicity is reflected in the Court of Appeals' discussion of the need for judicial approval of decisions to withdraw treatment, a step that was made mandatory under the constitutional law approach that was adopted by the lower appellate courts. Recognizing that responsible parties at times may need clarification of their legal rights and duties, the court stated that those in charge of incompetent patients may apply to the courts "for a ruling on the propriety of conduct which might seriously affect their charges." Such a procedure, though is entirely optional:

Neither the common law nor existing statutes require persons generally to seek prior court assessment of conduct which may subject them to civil and criminal liability. If it is desirable to enlarge the role of the courts in cases involving discontinuance of life-sustaining treatment for incompetents by establishing, as the Appellate Division suggested... a mandatory procedure of successive approvals by physicians, hospital personnel, relatives and the courts, the change should come from the Legislature.<sup>56</sup>

The New York court is not the first court to urge legislative action in this area. In response to cases such as *Quinlan*, *Saikewicz* and *Brother Fox*, legislatures in several states have passed "natural death" or "death with dignity" laws. Although legal experts have questioned the impact of these laws in light of the standards that have been developed in the courts, treatment of them here is necessary to a comprehensive understanding of the law regarding the withholding of medical treatment.

#### 4.) Legislative Approaches to Termination of Medical Treatment

Legislative attempts to solve the termination of treatment problem began

in 1976 with the passage of the California Natural Death Act.<sup>57</sup> By 1977, seven other states had passed similar legislation, but since then, only four states have done so.<sup>59</sup> Generally speaking, such legislation allows a person to execute a directive to his physician for the purpose of withholding medical treatment at some later date. Usually this is when the patient has reached a terminal state and is unable to exercise his right to refuse medical treatment. This legislation is not to be confused with so-called "definition of death" bills,<sup>60</sup> which only attempt to clarify the criteria to be used by physicians in determining when death has occurred. Although the determination of death will be related in some cases to the decision as to whether artificial means of life-support may be withdrawn, definition of death bills are only concerned with a physician's judgment and thus say nothing about the power to withdraw life-support from a patient who is clinically alive.

Most death with dignity bills declare a right to refuse life-prolonging medical treatment, and authorize persons to execute a legal document directing that such life-support measures cannot be used in certain circumstances. It is intended that this directive will be binding upon the treating physicians. This is an example of such a "living will" given in one statute:

TO MY FAMILY, MY CLERGYMAN, MY ATTORNEY, MY PHYSICIAN:

If the time comes when I can no longer actively take part in decisions for my own future, I intend this Declaration to stand as a statement of my wishes.

If due to an accident, disease or illness I have been reduced to a condition whereby I am unable to indicate my wishes or choices, and there is no expectation of my recovery, I request that I be allowed to die and not be kept alive by artificial means or heroic measures. I ask also that drugs be mercifully administered to me for terminal suffering, even if in relieving pain they may hasten the moment of death. I highly esteem and value life and the dignity of life, so that I am not asking that my life be directly taken; but it is my intention that, because there is no possibility of recovery, my dying not be unreasonably prolonged nor the dignity of my life destroyed by artificial contrivances.

This request is made, after careful reflection, while I am in good health and spirits. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing this grave responsibility with you that this statement is made.<sup>61</sup>

The more carefully-drafted versions of such statutes include a proviso that nothing in the act is to be construed to condone or authorize mercy-killing or any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.<sup>62</sup> Thus, the laws of homicide which condemn such mercy-killing by either act or omission remain intact.

Still, there remain some problems even with the most carefully drafted of these statutes. First, to the extent that such statutes attempt to direct the conduct of the physician at some future date, they fail to consider the physician's own medical judgment concerning the appropriateness of treatment. Such legislation should provide that the desires of the patient must be expressed in a manner that will assist the physician in handling the terminal case, without creating a mandatory duty to withdraw treatment. Second, such legislation



actually may inhibit physicians from respecting the wishes of the majority of terminal patients, who are unlikely ever to execute a "living will".

Whenever a statute is enacted to regulate conduct, particularly where punitive sanctions are available for non-compliance, the effect is to chill and inhibit similar conduct, otherwise legal, but not now in conformity with the requirements of the act. Thus, physicians may be reluctant to withdraw or withhold life-sustaining treatment unless a directive has been executed by the patient, even though there is no legal obligation to extend such care (as in the case of merely life-prolonging treatment). The California Natural Death Act attempts to address this problem by providing that it is not intended to impair any previously-existing right to withdraw life-preserving medical treatment. Similar legislation passed in Arkansas, however, was much more sloppily drafted and simply stated "all laws or parts of laws in conflict with this Act are hereby repealed."<sup>63</sup>

Other aspects of the Arkansas law demonstrate the dangers that can arise from death with dignity legislation. Section Two of the Act allows a person to write a directive rejecting any "artificial, extraordinary, extreme or radical method or surgical means or procedures calculated to prolong his life."<sup>64</sup> The act does not limit the situation where treatment may be withdrawn to that of terminal illness, not does it define the crucial terms "artificial", "extreme", or "extraordinary" or "radical". Presumably, the courts in Arkansas would not apply this statute as generally as a first reading of it would appear to allow. Even greater danger is found in Section Three of the Act, which allows a parent or guardian to execute such a directive refusing treatment for anyone, even a minor, who is mentally incapable of executing one, "or who is otherwise incapacitated." This last phrase is also undefined, opening the door to abuse.

Legislation such as that which was enacted in Arkansas can be assailed as a denial of the right to life without due process or equal protection of the laws in violation of the U.S. Constitution; it opens the door to legalized euthanasia. This illustrates the need to examine carefully and to monitor legislation considered in this area to ensure that necessary safeguards for the patient's most basic rights remain intact. Death legislation should be effective only in truly terminal cases. It must not allow the withdrawal of basic nourishment or sustenance. It must not allow withdrawal of ordinary medical means that are beneficial. It must ensure that consent was given voluntarily to any 'living will' or other consent form. It must prohibit mercy-killing and assisted suicide. And it must not seek mandatory control over a physician's judgment in some future undeterminable circumstance. Unless care is taken in each of these areas, such legislation, while intended to assist in the making of the most difficult of decisions, will only add more burdens to those faced with these choices, and, even worse, lead to an undermining of laws protecting the basic rights of patients.

## 5.) Legal Consensus on Termination of Treatment Decisions

Despite the uncertainties raised by death with dignity legislation and some

of the court decisions regarding termination of medical treatment, there is nevertheless an emerging consensus on the legal principles to be applied in such cases. For the incompetent patient, the consensus seems to be that medical treatment may be terminated by a physician when, in his medical judgment, treatment is useless, offering no medically reasonable hope or benefit. In that situation, treatment such as mechanical respiratory assistance may be terminated and the patient may be allowed to die as the natural consequence of the underlying disease process.

A physician is not mandated by law to render useless treatment. By "useless" it is meant that the continuation of the therapy cannot and does not improve the prognosis for recovery. Even if the therapy is necessary to maintain stability, such therapy should not be mandatory where the ultimate prognosis is hopeless. This does not mean that ordinary means of life-support, such as food and drink, can be discontinued merely because the ultimate prognosis is hopeless. It does mean, however, that physicians can exercise sound medical judgment and common sense in determining whether treatment is efficacious and, if it is not, then to cease the treatment. When the patient's illness is terminal and the end is near, society, through the physician, should be concerned with the easing the difficult burden of death with loving care and concern. This goal is not achieved through officious death-bed burdens such as sustained heroic treatment, flawed living wills, or mandatory court approval for decisions that are best guided by medical judgment.

The physician who withdraws treatment from the terminally ill patient whose death is imminent should not be held criminally or civilly liable for such conduct, when this care unduly prolongs life of the dying patient without holding out any reasonable hope of benefit. The withdrawal of treatment that only briefly forestalls imminent and inevitable death does not legally cause the death of the patient, since such conduct merely allows the underlying disease or illness to run its inevitable course.

We speak here of a limited class of cases, however. When referring to "treatment", we mean a regimen of medical care, as distinguished from ordinary care such as food and drink. Nourishment and palliative care should be given to all patients, even to those terminally-ill and from whom treatment has been withdrawn. When referring to "useless" treatment or "hopeless" cases, we mean those situation in which the decision to withdraw treatment is in essence a recognition that nothing more can be done for the patient, that the only sensible course is to withdraw treatment. The physician cannot be held liable for death here because he has not caused the patient to die. Rather, he simply has recognized, in exercise of sound medical judgment, that death from this disease or condition is inevitable *and* imminent.

A physician's judgment is *not* immune from legal intervention, however, where he has made a decision against treatment, and there is the issue presented by the case of the handicapped infant at risk who requires emergency surgery or other care to bring it past the crucial neonatal phase. The withholding of treatment from such infants is not justified by the consensus outlined above because such infants are not terminally ill, only suffering from a life-threatening condition. The judgment to refrain from correcting the life-threatening condition is not a judgment that death is inevitable, but rather, a judgment that the prospective "quality" of the infant's life is not worth the

expense of treatment.

The court in *Saikewicz* specifically rejected "quality of life" considerations playing any role in the decision by others to withdraw treatment from a minor or incompetent person. Thus, mercy-killing by omission for "quality of life" reasons, whether of handicapped infants or senile senior citizens, remains condemned in American law.

For most cases where termination of treatment is warranted, the opinions of the courts in *Dinnerstein*, *Brother Fox*, and *John Storar* are the correct ones. From *Dinnerstein*, we learn that in the ordinary and usual case where a patient is dying, the choice of treatment is the physician's. He does not need court authority to do what he, as a responsible physician, has been trained to do: make medical judgments. If those judgments become skewed, resulting in the violation of homicide or tort laws, then the law intervenes, as it should.

From *Brother Fox* and *Storar*, we learn that a competent adult has a common law right of self-determination to refuse medical treatment that does not need to be found in the Constitution, thus obviating perpetual judicial control of the death bed. That right of self-determination, however, does not extend automatically to the parent or guardian of an incompetent patient. Their role as spouse, guardian or family does not allow them direction of physicians' treatment, the performance or omission of which might be contrary to law. The power of self-determination that rests in the individual is never to be shifted for exercise by the substituted judgment of another individual.

## CONCLUSION

The law should not seek to control an area as sensitive as the death bed by requiring officious and intermeddling standards of legal conduct before medical judgment can be exercised. Rather, courts and legislatures exercise their proper function when they set the societal standards, as they have in the cases discussed here. The courts have properly required that, before treatment may be withdrawn, the patient must be in a terminal state where death is imminent and there exists no form of life-saving medical intervention or where the treatment would only prolong the dying state without hope of benefit or recovery.

A court proceeding should be required only where there is a dispute over whether this standard has been violated. The standard should be applied equally to all patients, handicapped and non-handicapped, infant and aged alike. Resignation to the inevitable death due to terminal disease, not a conscious decision to kill by means of withholding potentially beneficial or life-saving treatment, is all that has been authorized by the law. The latter course of mercy-killing remains condemned, and should be the subject of an expedited judicial remedy whenever a life hangs in the balance.

## NOTES

1. McCormick, Richard A., "To Save or Let Die: The Dilemma of Modern Medicine", *JAMA* 229:172 (1974); Weber, Leonard J., *Who Shall Live?* 105 (Paulist Press, N. Y., 1976); Duff, Raymond S., "Counseling Families and Deciding Care of Severely Defective Children: A Way of Coping with 'Medical Vietnam'", 67 *Pediatrics* 315, March 1981.
2. Horan, "Infanticide: When Doctor's Orders Read 'Murder'", *RN*, January 1982 at 75; "Defective Newborns are Dying By Design", *Hartford Courant*, June 14, 1981.
3. Ramsey, Paul, *The Patient as a Person*, 38 (Yale University Press, 1970); Robertson, "Involuntary Euthanasia of Defective Newborns: A Legal Analysis", 27 *Stan. L. Rev.* 213 (1975); Horan, "Euthanasia, Medical Treatment and the Mongoloid Child: Death as A Treatment of Choice", 27 *Baylor L. Rev.* 76 (1975).  
Fost, "Counseling Families Who Have a Child with a Severe Congenital Anomaly", 67 *Pediatrics* 321 (March 1981).
4. See Byrn, "Compulsory Lifesaving Treatment for the Competent Adult", 44 *Fordham L. Rev.* 62 (1975).
5. *Satz v. Perlmutter*, 379 So.2d 359 (Fla., 1980).
6. See *Matter of Sampson*, 29 N.Y.2d 900, 328 N.Y.S. 2d 686, 278 N.E.2d 918 (1972), *aff'd* 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Family Court, Ulster County); *Application of President and Directors of Georgetown College*, 331 F. 2d 1000 (1964); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576 (1969).
7. *Application of President and Directors of Georgetown College*, *id.*
8. *In Re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663-664 *cert. denied sub nom. Garger v. N.J.*, 429 U.S. 922 (1976).
9. 70 N.J. at 41, 355 A.2d at 664.
10. *Id.*
11. *Id.* at 50, 355 A.2d at 668.
12. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977).
13. *Id.* at 739-740, 370 N.E. 2d at 424.



14. *Id.*
15. 70 N.J. at 33, 355 A. 2d at 663.
16. *Id.*
17. 373 Mass. at 755, 370 N.E. 2d at 434.
18. Matter of Earle N. Spring, 405 N.E. 2d 115, 120 (Mass., 1980)
19. See, e.g. Paris, "Brother Fox, the Courts and Death With Dignity, *America* at 282 (Nov. 8, 1980); McCormick, "Commentary: The Fox Case", 244 *JAMA* 2165 (1980).
20. 405 N.E. 2d at 120-122.
21. Superintendent v. Saikewicz, 373 Mass. 728, 370 N.E. 2d 417 (1980).
22. Matter of Spring, 405 N.E. 2d 115 (Mass., 1980).
23. *Id.* at 119.
24. *Id.* at 118.
25. Matter of Shirley Dinnerstein, 380 N.E. 2d 134 (Mass. App. Ct., 1978).
26. *Id.*
27. *Id.* at 138-139.
28. In Re Custody of a Minor, N.E. 2d , (Mass. App. Ct., 1982).
29. Hoyt v. St. Mary's Rehabilitation Center, (Dist. Ct., Hennepin County, Minn., opinion date, February 13, 1981).
30. 421. A. 2d 1334 (Del. 1980).
31. *Id.* at 1349
32. The court decisions regarding Infant Doe are unreported. Information regarding the case has been gleaned from various newspaper reports and interviews with attorneys involved in the case. Infant Doe was born on April 9, 1982, and died six days later.
33. Maine Medical Center v. Houle, No. 74-145, Superior Court, Cumberland, Maine, decided February 14, 1974.
34. In Re Application of Cicero, 421 N. Y. S. 2d 965 (S. Ct. 1979).
35. Custody of a Minor, 375 Mass. 73, 379 N.E. 2d 1053 (Mass. 1978).

36. In Re Storar, 52 N. Y. 2d 1008, 438 N. Y. S. 2d 266, 420 N.E. 2d 64 (1981). (Opinion of the New York Court of Appeals in the consolidated cases of Brother Fox and John Storar).
37. In Re Eichner (Fox), 102 Misc. 2d 184, 186, 423 N. Y. S. 2d 580, 582 (1979).
38. Eichner v. Dillon, 73 A.D. 2d 431, 434, 426 N. Y. S. 2d 517, 523 (1980).
39. See in Re Eichner, 102 Misc. 2d 184, 188-193, 423 N. Y. S. 2d 580, 584-587
40. 102 Misc. 2d at 200, 423 N. Y. S. 2d at 591.
41. *Id.*
42. Eichner v. Dillon, 73 A.D. 2d 431, 461, 472, 426 N. Y. S. 2d 517, 540, 548 (1980).
43. *Id.* at 472, 426 N. Y. S. 2d at 548.
44. *Id.* at 461, 426 N. Y. S. 2d at 540.
45. See discussion, *supra*.
46. 73 A.D. 2d at 476-477, 426 N. Y. S. 2d at 550-551.
47. 73 A.D. 2d at 468, 426 N. Y. S. 2d at 545.
48. In Re Storar, 52 N. Y. 2d 1008, 438 N. Y. S. 2d 266, 420 N.E. 2d 64 (1981).
49. 438 N. Y. S. 2d at 271, 420 N.E. 2d at 69.
50. *Id.* at 272, 420 N.E. 2d at 70.
51. *Id.*
52. 433 N. Y. S. 2d 388 (S. Ct. Monroe County, 1980).
53. 438 N. Y. S. 2d at 275, 420 N.E. 2d at 73.
54. *Id.*
55. *Id.*
56. *Id.*
57. Cal. Health and Safety Code Secs. 7185-7195 (1977).

58. Arkansas, Idaho, Nevada, Texas, North Carolina, New Mexico, Oregon.
59. Alabama, Kansas, Washington and the District of Columbia.  
List as of June 1, 1982.
60. *See, e.g.* Michigan Rev. Stat., Sec. 333, 1021.
61. Language taken from Senate Bill No. 19, introduced in Delaware State Senate, 131st General Assembly, January, 1981
62. *Id.* at Section 3: "Nothing in this Act shall be construed to condone, authorize or approve of mercy killing, be construed to permit the natural process of dying; nor be construed to be a method of defining or determining a technical state of death.
63. Ark. Stat. Ann. Sec. 82-3801-3804 (1977).
64. *Id.* at Sec. 3 (g).