Involuntary Passive Euthanasia of Brainstem-Damaged Patients: The Need for Legislation - An Analysis and a Proposal

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INTRODUCTION

In recent years the practice by physicians of involuntary passive euthanasia¹ in the form of withholding or withdrawing life-support systems from brain-stem-damaged patients has become widespread.² This practice exists even though terminating treatment which hastens the death of a patient arguably constitutes culpable homicide under traditional legal standards.³ Our society is now faced with two principal choices: accepting the practice of allowing the attending physician to determine his own standards for terminating life; or regulating the practice by enacting legislation setting forth legal standards for terminating life.

This Comment will examine present medical and legal standards regarding involuntary passive euthanasia of brain-stem-damaged patients and propose a statute to legalize involuntary passive euthanasia under certain restrictive conditions.

MEDICAL STANDARDS REGARDING THE TREATMENT OF BRAIN-STEM-DAMAGED PATIENTS

The Use of Life Support Systems to Save Potentially Brain Damaged Patients

The physician’s decision to prolong or terminate the life of a brain-stem-damaged patient is a recent medical problem. Prior to the use of new life-support systems, many of these patients would die

¹. The term "involuntary passive euthanasia" is used here to denote the withholding of treatment from a patient without his consent, as opposed to "voluntary active euthanasia," which occurs when the patient consents to active treatment to cause his death.
². See text accompanying notes 17–23 infra.
³. See text accompanying notes 30–42 infra.
of natural causes. Deprivation of oxygen, either through the interruption of the blood supply or oxygenation of the blood, causes brain damage. All brain damage is irreversible, but the degree of damage is determined by the duration of the interruption of oxygen. If the brain is deprived of oxygen for three to five minutes, all of the cells in the cerebral cortex, which controls consciousness, thinking, and reasoning, are destroyed. After fifteen minutes, the rest of the cells in the midbrain and brain stem are destroyed, and the brain can no longer maintain vital bodily functions, including spontaneous breathing and heartbeat, and the patient dies.

The application of life-support systems by the physician can interrupt the above sequence of events. It is now possible to maintain both circulation and respiration by mechanical means. A cardiac pacemaker wired to the heart maintains circulation by rhythmically discharging electrical current, causing the heart to contract. A respirator completely takes over breathing, controlling the exact flow of oxygen and corresponding exit of carbon dioxide. An immediate application of these machines will restore oxygen to the brain and prevent its further destruction.

There are times when cerebral functioning is absent, but restoration is still possible. Therefore, an unconscious patient rushed to an emergency room after suffering cardiac arrest will immediately be placed on these machines in an effort to save his life. Unfortunately, the application of these devices is frequently only partially successful, and the physician is left with a patient whose heartbeat or respiration is maintained mechanically, but whose brain is severely and irreversibly damaged.

The cost of sustaining such patients can be extremely high. First, the family or relatives are faced with an emotional and financial drain. Second, the community must provide medical staff and

4. See 3 M. HOUTS & I. H. HAUT, COURTROOM MEDICINE § 1.01 (2) (a) (1971).
5. Id. § 1.01 (3) (d).
7. Id.
10. Olinger, Medical Death, Id. at 22.
12. In the case of Karen Ann Quinlan, discussed in text accompanying notes 76-92 infra, a severely brain-damaged patient required a respirator
costly medical facilities.\textsuperscript{13} Finally, other patients may be denied access to medical services.\textsuperscript{14}

Respirators and pacemakers, non-existent a short time ago, are now being widely utilized.\textsuperscript{15} With increased application of these devices, a standard of prolonging “life” as long as possible means that “immense resources would have to be employed to provide care for ever increasing numbers of irreversibly comatose patients being sustained indefinitely at a level of existence commonly disparaged as akin to that of a ‘vegetable.’”\textsuperscript{16}

\textbf{The Withdrawal of Life-Support Systems to Permit Dying}

With the physician’s increased capacity to treat brain-damaged patients, the traditional view that decisions of treatment should be made entirely on the basis of physiological aspects is giving way to the more modern view that social as well as physiological factors should be considered.\textsuperscript{17} These sociological factors include: (1) whether the patient is salvageable; (2) the quality of life to which

in order to be kept alive. The medical costs were $450 a day. The San Diego Union, Nov. 2, 1975, at C-1, col. 1.

\begin{enumerate}
  \item Dr. Walter Sackett testified before a U.S. Senate Subcommittee in 1972 that Florida had 1,500 severely retarded patients and
  
  \begin{quote}
  \begin{itemize}
  \item The kidney dialysis group was asking for $500,000, and when he said the State doesn’t have it, this meant that we are going to have to let 125 people, half of the people who had treatable kidney disease in Florida had to be allowed to die. . . . Now where is the benefit in these 1,500 severely retarded, who never had a rational thought, and still we are going to let 125 people whose lives could be prolonged in a useful state . . . die because we are pouring all this money into these huge institutions?
  \end{itemize}
  \end{quote}

\end{enumerate}
the patient can be expected to return; (3) whether the patient can measurably benefit from further treatment; and (4) the adverse effects continued treatment may have on the patient's family or other patients.18

The application of these sociological considerations in determining treatment has led to the widespread practice of involuntary passive euthanasia of brain-stem-damaged patients.19 In 1974, testimony before a Senate Subcommittee pointed out that "about three-fourths of American physicians say they practice 'passive' euthanasia regularly—that is they withdraw artificial life support and permit dying."20 This practice is not limited to adult patients, but seems especially prevalent among defective newborns.21 "At least once a week, a doctor somewhere in the Washington metropolitan area decides that one of his infant patients has no chance of meaningful life and withholds medical treatment needed to keep the child alive."22 It is estimated overall that "several thousand" infants per year die as a result of having treatment withheld or withdrawn.23

The medical community has not articulated any guidelines to aid the physician in his decision to terminate treatment. It is only within the last five years that a few teaching hospitals have established ethics committees to aid the physician in such decision.24 As a result, the decision about when and under what conditions treatment should be terminated has been left solely to the attending

18. Id. 3-13. Ms. Crane also lists two other possible factors: (1) if the patient is rational his attitude toward the resumption of his social roles; and (2) the relative value or social worth of the patient's roles.
23. See Medical Ethics, supra note 20, at 26. "Approximately 7,500 infants with severe mental or physical handicaps are born in this country each year to mothers over thirty-five. . . . One of the most common problems is Down's Syndrome (mongolism)." HEIFETS & MANDEL, THE RIGHT TO DIE 49 (1975).
24. S.F. Chronicle, July 21, 1976, at 14, col. 1. The article cites only four hospitals that have established ethics committees: Massachusetts General Hospital in Boston, University of Virginia in Charlottesville, Children's Hospital of Pittsburgh, and Johns Hopkins in Baltimore.
physician. He is guided only by his medical expertise, morals, and conscience. Given the nature of these factors, it is doubtful that a uniform standard is being applied. The use of social criteria for making these decisions is inherently ambiguous because “it is very difficult to say at what point an alert individual ceases to interact meaningfully with his social environment.” The physician must decide when a human being is no longer a human being. There is a spectrum of existence from alert consciousness to cellular life and it becomes a question of picking somewhere along the spectrum. Finally, one can expect the standard of treatment to vary depending upon such factors as the physician’s personal background, the geographical area of practice, and the specific economic or social class of the patient or the patient’s family.

The practice of involuntary passive euthanasia under these circumstances is susceptible to abuse or mistake. One example of abuse is an incident in which the attending physician acquiesced in the parents’ request not to operate on a “Down’s Syndrome” baby with duodenal arteresa. The parents did not want the burden of a mongoloid child. It took the baby fifteen days to die of starvation. The tragedy of this case is that except for brain damage, the child would have been reasonably healthy, requiring a limited amount of medical care.

While the medical community can determine when a patient is suffering from irreversible brain-stem-damage, the question of what should be done with such an individual remains. The answer is not simply a technical medical matter.

LEGAL STANDARDS REGARDING INVOLUNTARY PASSIVE
EUTHANASIA OF BRAIN-STEM-DAMAGED PATIENTS

Traditional Common Laws: Responsibility of the Physician for Homicide

The practice of involuntary passive euthanasia by withholding or withdrawing life-support systems from brain-stem-damaged patients which hastens the death of that patient arguably constitutes unlawful homicide. I say “arguably” because there are no

25. Crane, supra note 17, at 3.
reported cases of a physician being indicted for homicide arising out of terminating treatment which has accelerated his patient's death.\textsuperscript{29}  

The Law of Homicide

Murder is the killing of another human being with malice aforethought.\textsuperscript{30} Malice does not require ill will, but merely the intent to kill or inflict bodily injury.\textsuperscript{31} As explained by the court in \textit{People v. Conley},\textsuperscript{32} "one who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice . . . ."\textsuperscript{33}

Humanitarian motives have never been a defense to murder.\textsuperscript{34} The court in \textit{State v. Ehlers}\textsuperscript{35} pointed out "[i]f the proved facts established that the defendant did the killing willfully, that is, with the intent to kill . . . there is murder . . . no matter what defendant's motive may have been . . . ."\textsuperscript{36} The fact that the victim is dying does not relieve criminal responsibility.\textsuperscript{37} In \textit{State v. Francis}\textsuperscript{38} modified and remanded, 137 N.J. 10, 335 A.2d 647 (1976), discussed in text accompanying notes 76-92 infra.

\textsuperscript{29.} See Fletcher, \textit{Prolonging Life}, 42 WASH. L. REV. 999 (1967); Sanders, \textit{Euthanasia: None Dare Call It Murder}, 60 J. CRIM. L. 351 (1969).

\textsuperscript{30.} R. PERKINS, \textit{PERKINS ON CRIMINAL LAW} 28 (2d ed. 1969).

\textsuperscript{31.} Id. at 35.

\textsuperscript{32.} 64 Cal. 2d 310, 411 P.2d 911, 49 Cal. Rptr. 815 (1966).

\textsuperscript{33.} Id. at 332, 411 P.2d at 918, 49 Cal. Rptr. at 822.

\textsuperscript{34.} People v. Tice, 257 Iowa 84, 130 N.W.2d 678 (1964); State v. Ehlers, 98 N.J.L. 236, 119 A. 15 (1922).

\textsuperscript{35.} Id. at 240, 119 A. at 17.

\textsuperscript{36.} 152 S.C. 17, 149 S.E. 348 (1929). In\textit{ Francis} the victim was stabbed,
the court stated that "if any life at all is left in a human body, even
the least spark, the extinguishment of it is as much homicide as
the killing of the most vital being." Humanitarian motives and
the victim's hopeless condition, which distinguish involuntary pas-
sive euthanasia from other forms of murder, are irrelevant under
common law.

Culpable homicide is the killing of a living human being. Therefore, under common law the killing of an unborn but viable
fetus is infanticide, not homicide, because the fetus is not considered
a living human being. The biological life characteristics of an
unborn but viable fetus are similar to those of a severely brain-
damaged patient; both have physiological life, but neither has full
consciousness. It may be contended that a human being is no
longer a human being when he has lost his ability to maintain a
conscious, reasoning, and thinking state. It follows that the
removal of life-support systems from a severely brain-damaged pati-
extant which hastens the patient's death is not murder because the
patient is not a human being. Whatever the merits of such an argu-
ment, it would merely reduce the physician's responsibility to the
analogous crime of infanticide.

The Physician's Obligation to Continue Treatment

A physician's responsibility for homicide arises only if he has a
legal duty, as opposed to a moral obligation, to act. A physician
is under no legal duty to accept a patient, nor is the physician
legally required to render aid to one who is dying. The physi-

39. Id. at 60, 149 S.E. 348 at 364.
40. W. LaFAve & A. Scott, CRIMINAL LAW 530 (1972).
41. PERKINS, supra note 30, at 29.
42. See Elkinton, The Dying Patient, The Doctor and The Law, 13 Vill.
L. REV. 740 (1968); Olinger, supra note 10.
43. People v. Beardsley, 150 Mich. 206, 113 N.W. 1128 (1907); See Per-
kins, supra note 30, at 592-600.
44. Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901); Rice v.
45. Agnew v. Parks, 172 Cal. App. 2d 756, 343 P.2d 118 (1959); Butters-
cian's legal duty to provide care arises by contract, either express or implied, or by law, if he voluntarily undertakes to provide care. As a general rule, even though the withholding of treatment constitutes an omission, if there is a legal duty imposed by law or contract, and the omission to perform that duty results in the death of the person to whom that duty was owed, the person failing to perform such a duty has committed unlawful homicide.

The legal duty of the physician to provide care, once initiated, must continue until it is ended by consent or revocation, or until the physician's services are no longer needed. It could be argued that when a brain-damaged patient is in a persistent vegetative state, the physician's services are no longer needed, and the physician therefore has no further legal obligation to maintain treatment. Unfortunately, there is little, if any, case law to indicate when a physician's services are no longer needed. A few cases (not involving physicians) have held that when a defendant incurs a legal duty by undertaking to provide care, no liability will be imposed unless the defendant's conduct has made the party worse off than he was before. At least in severe brain damage cases, the physician might contend that by removing life-support machines the patient

worth v. Swint, 53 Ga. App. 602, 186 S.E. 770 (1936); Hurley v. Edding- 
field, 156 Ind. 416, 59 N.E. 1058 (1901).

46. Thaggard v. Vafes, 218 Ala. 609, 119 So. 647 (1929); Spencer v. West, 
126 So. 2d 423 (La. App. 1960); Peterson v. Phelps, 123 Minn. 319, 143 
N.W. 793 (1913).

47. Pallis v. State, 123 Ala. 12, 26 So. 339 (1899); State v. Benton, 38 
Del. 1, 187 A. 609 (1936); Westrup v. Commonwealth, 123 Ky. 95, 93 S.W. 
646 (1906). For a discussion of whether the act of turning off a mechanical 
respirator constitutes an act or omission, see Fletcher, Prolonging Life, 
42 Wash. L. Rev. 999 (1967).

48. Dale v. Donaldson Lumber Co., 48 Ark. 188, 2 S.W. 703 (1887); Miller 
v. Dore, 154 Me. 363, 148 A.2d 692 (1959); Schmit v. Esser, 183 Minn. 354, 
236 N.W. 622 (1931); Boyd v. Andrae, 44 S.W.2d 891 (Mo. App. 1932); Hal- 
verson v. Zimmerman, 60 N.D. 113, 232 N.W. 754 (1930); Welch v. Frisbie 
Memorial Hospital, 90 N.H. 337, 9 A.2d 761 (1939); McManus v. Donlin, 23 
Wis. 2d 289, 127 N.W.2d 22 (1964).

49. In In re Karen Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), discussed 
in text accompanying notes 76-92 infra, the court held that an irreversibly 
brain-damaged patient's life-support system could be removed even though 
the patient was alive. However, the decision was based on the patient's 
constitutional right of privacy to terminate treatment as exercised through 
her legal guardian. One must distinguish between the physician's services 
being terminated because of revocation by the patient and the physician's 
services being terminated because the physician feels his services are no 
longer needed.

50. United States v. DeVane, 306 F.2d 132 (5th Cir. 1962); Lacey v. 
App. 2d 532, 131 P.2d 56 (1942); Kuchynski v. Ukyn, 89 N.H. 400, 200 A. 
416 (1938).
has not been made "worse off." The essence of this argument, taken to its logical conclusion, is that the patient was, for all practical purposes, dead.

Finally, it has been suggested that even though a doctor has a duty to continue treatment, his duty extends only to ordinary means of care.51 An often quoted guideline between ordinary and extraordinary care is the statement of Pope Pius XII52 that a doctor is not obligated to provide care "which cannot be obtained by or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit."53 Following this guideline, a physician does not have a duty to maintain brain-stem-damaged patients on life-support devices because there is no reasonable hope of future benefit. This distinction between ordinary and extraordinary care, however, has not been recognized by case law, nor is it "necessarily the view a court would take of the law."54

Legal Definition of Death

By definition, homicide cannot be committed on a person who is dead.55 Thus, the criminal responsibility of the physician for removing life-support machines may depend upon the legal definition of death. However, present legal standards offer the physician little leeway. The traditional legal definition of death is "[t]he cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc."56

53. Id.
This traditional legal definition of death—the total cessation of circulation—has come under increasing attack with the advent of organ transplantation and artificial devices for maintaining life. A surgeon has very little time to remove a heart, liver, or lung from the donor and transplant it to the donee. If the physician has to wait until there is a total cessation of circulation before removing the donor's organ, the organ will have already begun to deteriorate, thus significantly reducing the chances of a successful transplant. To meet the requirements for transplantation, the medical community proposed the adoption of a total brain-death standard.


58. Wasmuth, supra note 8.
60. The most widely accepted criterion is that of the Ad Hoc Committee of the Harvard Medical School. The Harvard Committee explains total brain death as follows:

An organ, brain, or other, that no longer functions and has no possibility of functioning again is for all practical purposes dead. Our first problem is to determine the characteristics of a permanently nonfunctioning brain.

A patient in this state appears in a deep coma. The conditions satisfactorily diagnosed by points A, B, and C to follow. The encephalogram (point D) provides confirmatory data, and when available it should be utilized . . . .

A. Unreceptivity and Unresponsitivity

There is a total unawareness of externally applied stimuli and inner need and complete unresponsiveness—our definition of irreversible coma. Even the most intensely painful stimuli evoke no vocal or other response, not even a groan, withdrawal of a limb, or quickening of respiration.

B. No Movements or Breathing

Observations covering a period of at least one hour by physicians are adequate to satisfy the criteria of no spontaneous muscular movements or spontaneous respiration or response to stimuli such as pain, touch, sound, or light. After the patient is on a mechanical respirator, the total absence of spontaneous breathing may be established by turning off the respirator for three minutes and observing whether there is any effort on the part of the subject to breath spontaneously. (The respirator may be turned off for this time provided that at the start of the trial period the patient's carbon dioxide tension is within the normal range, and provided also
The adoption of the brain-death standard means that the surgeon may remove the organ while circulation or respiration is maintained mechanically, thus preventing deterioration of the organ.\textsuperscript{61}

The total brain-death standard has come before the courts twice. In 1972, in \textit{Tucker v. Lower},\textsuperscript{62} a physician was sued for the wrongful death of a heart transplant donor. The patient suffered total brain death and was being sustained artificially prior to removal of the heart. The plaintiff maintained that under the traditional legal standard, the surgeon caused the death of the patient because he removed the heart while it was still beating. The judge gave an unprecedented instruction and told the jury they could consider irreversible loss of all function of the brain as a criterion for determining death.\textsuperscript{63} The jury found in favor of the defendant sur-

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\textbf{C. No Reflexes}

Irreversible coma with abolition of central nervous system activity is evidenced in part by the absence of elicitable reflexes. The pupil will be fixed and dilated and will not respond to a direct source of bright light. Since the establishment of a fixed, dilated pupil is clear-cut in clinical practice, there should be no uncertainty as to its presence. Ocular movement (to head turning and to irritation of the ears with ice water) and blinking are absent. There is no evidence of postural activity (decerebrate or other) swallowing, yawning, vocalization are in abeyance. Corneal and pharyngeal reflexes are absent . . . .

\textbf{D. Flat Electroencephalogram}

Of great confirmatory value is the flat or isoelectric EEG . . . . We consider it prudent to have one channel of the apparatus used for an electrocardiogram. This channel will monitor the ECG so that, if it appears in the electroencephalographic leads because of high resistance, it can be readily identified. It also establishes the presence of the active heart in the absence of the EEG. . . . The apparatus should be run at standard gains 10 v/mm, 50 v/mm. Also it should be isoelectric at double this standard gains which is 5 v/mm or 25 v/mm. At least ten full minutes of recording are desirable, but twice that would be better.

All of the above tests shall be repeated at least 24 hours later with no change.


63. The instruction in \textit{Tucker} was as follows:
geon. However, because it was a general verdict, it cannot be said with certainty that the jury accepted the brain-death criterion.

In 1974, in People v. Lyons, an individual was shot in the head during an argument. After the victim had been sustained artificially for two days, the doctors determined that he had suffered total brain death and removed the heart for transplantation. The person who shot the victim was charged with murder. He raised the defense that under the traditional legal definition of death the victim did not die until his heart was removed by the surgeon. The judge ruled as a matter of law that the victim was dead when "based upon the usual and customary standards of medical practice, it is determined that the person has suffered an irreversible cessation of brain function."

Neither Tucker nor Lyons was appealed. As a result of these cases and the need to meet organ transplantation requirements, at least seven states have enacted brain-death statutes. The California brain-death statute provides: "A person shall be pronounced dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function . . . ."

Even under the total brain-death standard there are still irreversibly brain-damaged patients in a persistent vegetative state with no cognitive functioning who are legally alive. The total brain-death standard requires that all the cells of the cortex, midbrain, and brain stem be dead. Therefore, a brain-damaged patient with

In determining the time of death, as aforesaid, under the facts and circumstances of this case, you may consider the following elements, none of which should necessarily be considered controlling, although you may feel under the evidence that one or more of these conditions are controlling: The time of the total stoppage of the circulation of blood; the time of total cessation of the other vital functions consequent thereto, such as respiration and pulsation; the time of complete and irreversible loss of all function of the brain; and, whether or not the aforesaid functions were spontaneous or were being maintained artificially or mechanically.


65. No. 56072 (Cal. Sup. Ct., Oakland, Ca., 1974). See Friloux, supra note 64.


68. This was the state of Karen Ann Quinlan. In re Karen Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), discussed in text accompanying notes 76-92 infra.

69. See note 60 and accompanying text supra.
total cortex and midbrain death, and only partial brain stem death, destroying consciousness, hearing, speaking, reasoning, and thinking, is still legally alive under the brain-death standard.\textsuperscript{70}

The possibility of criminal prosecution exists even though the physician's responsibility for homicide arising out of terminating treatment of brain-stem-damaged patients is unclear. Some argue that tolerating nontreatment by physicians to permit dying opens a wedge for further, more drastic forms of euthanasia.\textsuperscript{71} They conclude that there should be strict enforcement of criminal homicide laws to stop such practices. The strict enforcement of criminal homicide laws, however, is not a solution to the present problem. First, it is likely to force the practice to go further underground. Physicians are likely to become more secretive. There is already an unwritten medical practice of not resuscitating terminally ill patients.\textsuperscript{72} If this practice were to be applied to brain-damaged patients, it would increase the likelihood that a patient who might be able to return to some form of a cognitive state would die.\textsuperscript{73} Even if physicians were to place their patients on the respirators at the outset, the desired result could be reached by failing to maintain the machine.\textsuperscript{74} Second, homicide laws work after the fact. No action would be taken against the physician until after the patient is already dead. Finally, the fear of criminal prosecution might create an undesirable backlash in which the physician would decline to undertake treatment of patients whose chances for success, although possible, were not probable.\textsuperscript{75}

Recent Developments: The Legalization of Limited Forms of Euthanasia

Two jurisdictions, one by judicial decision, and the other by legislation, have recently adopted legal standards which allow a physician to terminate treatment to permit dying.

\textsuperscript{70} See text accompanying notes 4-11 supra.


\textsuperscript{72} In re Karen Quinlan, 70 N.J. 10, 29, 355 A.2d, 647, 657 (1976). Testimony by Dr. Koran: "No physician that I know personally is going to try and resuscitate a man riddled with cancer."

\textsuperscript{73} See text accompanying notes 4-11 supra.

\textsuperscript{74} CRANE, supra note 17, at 74.

\textsuperscript{75} A physician is not required to accept a patient. See note 45 and accompanying text supra.
The Quinlan Case

On March 31, 1976, the New Jersey Supreme Court in In re Karen Quinlan held that an irreversibly brain-damaged patient's life-support systems could be removed even though the patient was legally alive under both standards. Thirteen months prior to the decision, Karen Ann Quinlan had suffered irreversible brain damage which left her in a persistent vegetative state with no cognitive functioning. She used a respirator to maintain breathing. Karen's parents requested that the life-support machines be turned off, and in what is now an unusual case, the physician refused to comply. As a result, Mr. Quinlan sought relief from the courts requesting an order to have the machines removed.

In the initial consideration of this relief, the New Jersey Superior Court rejected the Quinlans' request. It predicated its holding on the finding that the decision to determine appropriate treatment is only within the competence of the attending physician, and that the removal of the life-support machines would constitute unlawful homicide.

On appeal, the New Jersey Supreme Court reversed the superior court's decision. Drawing upon the United States Supreme Court's decisions recognizing the constitutional right of privacy, the New Jersey Supreme Court held that the right of privacy "was broad enough to encompass a patient's decision to decline medical treatment under certain conditions"—the conditions being limited to the finding that there was no compelling state interest essential to the preservation and sanctity of human life. Under this doctrine, a number of courts have compelled patients to undergo life-saving medical treatment; but in all of these cases the chances of recovery to a functioning life were extremely high. As the New

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77. Id. at 23, 355 A.2d at 654.
Jersey Court pointed out, "the State's interest . . . weakens and the individual's right of privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest." The New Jersey Supreme Court found that there was no compelling state interest to keep Karen alive if the hospital's Ethics Committee or a like body agreed that there was no reasonable possibility of Karen emerging from her comatose condition to a cognitive, sapient state.

The holding in Quinlan that the state does not have a compelling interest to preserve all forms of biological life is supported by Roe v. Wade. There the Supreme Court stated: "With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. This is so because the fetus then presumably has the capacity of meaningful life outside the mother's womb."

The New Jersey Supreme Court in Quinlan recognized that a comatose patient cannot consciously exercise her constitutional right of privacy. Therefore, the court held that the only way to prevent the destruction of this right was to appoint a guardian who would render his best judgment as to whether the patient would exercise the right under the circumstances.

Finally, with regard to the criminal responsibility of the physician for removing the life-support machines, the court stated that the constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right. Therefore, they would not be subject to civil or criminal liability.


85. Id.
86. 410 U.S. 113 (1973).
87. Id. at 163.
89. Id. at 52, 355 A.2d at 670.
The *Quinlan* case is of somewhat limited value in terms of legally regulating the current practice of involuntary passive euthanasia of brain-stem-damaged patients by physicians. First, while *Quinlan* provides certain guidelines for a physician to follow, it does not provide any mandatory pre-termination review by a judicial body. If a court is to be involved in the decision-making process, the initiative would have to come from the physician himself. He would have to voluntarily give up his decision-making role and request that the court appoint a guardian in the hope that the guardian would request the removal of the machines. Second, *Quinlan* represents a single decision in one jurisdiction. An attempt to set out a uniform legal standard would require a series of court decisions, and it is extremely undesirable for the physician's legal "duty to be set down piecemeal as the result of decided cases."90

However, under *Quinlan*, any physician who was truly concerned with criminal prosecution could avoid such prosecution and possibly achieve the desired results by seeking a court order to remove the machines.91 In addition, *Quinlan* is valuable as persuasive authority to uphold legislation legalizing involuntary passive euthanasia against a constitutional attack that the state has an interest to preserve the sanctity of life.92

California's Natural Death Act

California is the second jurisdiction which has recently legalized termination of medical treatment under certain conditions. On September 30, 1976, California enacted "The Natural Death Act."93 The statute allows a competent adult to execute a "Directive to the Physician" (see Appendix A infra). In the directive, the individual declares that should he have an incurable injury, disease, or illness, which is terminal, and the application of life-sustaining procedures is or would only postpone an imminent death, whether or not such procedures are utilized, such procedures are to be withheld or withdrawn.

The statute defines "terminal condition" as: "an incurable condition caused by injury, disease, or illness which, regardless of the

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91. On February 11, 1977, Tennessee Chancery Court Judge Herschel Franks ruled that doctors could legally turn off a respirator that had kept the comatose patient Della Dockery breathing for three months. Judge Franks said that the attending physician must find that there is no possibility of the patient ever emerging from her comatose condition. The decision is expected to be appealed. The San Diego Union, Feb. 12, 1977, at A-15, col. 3.
92. See text accompanying notes 90-93.
application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.\textsuperscript{94} “Life-sustaining procedures” are defined as:

any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized.\textsuperscript{95}

The attending physician prior to taking any action must determine whether the directive complies with the statutory requirements. If these requirements are met, the physician is to carry out the desires of the patient and withhold or withdraw life-sustaining procedures.

A directive is effective for five years and if the declarant becomes comatose, the directive shall remain in effect for the duration of the comatose condition. The statute also provides that a physician acting in accordance with the provisions shall not be civilly liable or guilty of any criminal act.

The California statute does not go far enough in its application with regard to the practice of involuntary passive euthanasia of brain-stem-damaged patients. The statute has no effect in legalizing the withholding or withdrawal of treatment of children or of those adults who have not had the foresight to make out a directive before becoming comatose.

A New Legal Standard for the Treatment of Brain-Stem-Damaged Patients

The Need for a New Legal Standard

Regardless of the advantages or disadvantages of permitting involuntary passive euthanasia,\textsuperscript{96} the practice is widespread among

\textsuperscript{94} Id. § 7187(f).
\textsuperscript{95} Id. § 7187(c).
physicians treating brain-stem-damaged patients. The issue now is whether new legal standards should be enacted to regulate the practice. Presently, the decision about when and under what conditions treatment should be terminated is left solely to the attending physician. *Quinlan* does not provide any mandatory pre-termination review by a judicial body, and it is unlikely that the physician will give up his decision-making role and begin voluntarily requesting judicial determination. The California statute affects only competent adults who have had the foresight to make out a directive.

Unfortunately, when the decision is left solely to the attending physician, the possibility of mistake or abuse exists. This situation is especially true when the practice is shrouded in secrecy because of the fear of possible criminal prosecution. There are no articulated standards to guide the physician in his decision. The decision on whether to prolong or terminate life is made daily and is "governed only by the dictates of conscience and social pressure on one extreme and the law of homicide on the other."*86

The law in any society is a social instrument used to control human behavior to meet the needs of that society. To meet the needs of society, the law must now establish effective legal standards to regulate the practice of involuntary passive euthanasia in order to protect the public against the premature killing of patients whose deaths were not otherwise inevitable. Society is ill served if our legal system does not establish formal guidelines and procedures for making such decisions.*99

A Proposed Statute Regulating Involuntary Passive Euthanasia

A statute legalizing euthanasia must deal with at least three major factors: (1) specific criteria defining the medical status of a patient whose treatment may be terminated, (2) procedural guidelines for applying those criteria, and (3) provisions for the statute's enforcement.

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97. See text accompanying notes 19-23 *supra*. A similar problem existed with abortions prior to the *Roe* decision. A large number of illegal abortions were being performed. Regardless of the moral considerations of abortion, the question became whether abortions should be legalized to regulate this underground practice. The need to legalize this practice for the purpose of regulation became very important because of those people in the lower economic class who could not afford to pay for quality "black market" medical services. A significant mortality rate resulted among these women.


99. See *Steel & Hill*, *supra* note 19. They propose a "self-death" statute which would legalize both voluntary and involuntary euthanasia.
The following is a proposed involuntary euthanasia statute:

SECTION 1. Subject to the provisions of this act, it shall be lawful for a physician to withhold or withdraw life-sustaining procedures from a qualified patient.

SECTION 2. For the purposes of this act:

(1) “Physicians” means a medical practitioner licensed under the appropriate state statutes;

(2) “Life-sustaining procedures” means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would only serve to prolong an imminent death.

(3) “Qualified patient” means an individual, in respect to whom two physicians, one being of consultant status, have certified in writing that the patient is suffering from a condition of brain damage or deterioration such that the patient has irrecoverably and irreversibly lost consciousness and the capacity to think and reason.

The certification will also indicate all efforts taken to treat such an individual.

SECTION 3. Before a physician may withhold or withdraw life-sustaining procedures pursuant to the provisions of this act, the physician, hospital, parents, guardian or relatives must petition the court for an order authorizing the withholding or withdrawal.

Upon receipt of the petition, the court shall within five days appoint a legal guardian. Within ten days after the petition a hearing shall be held to determine if the patient is a qualified patient under the provisions of this act. If the court finds that the patient is a qualified patient it shall issue an order authorizing the withholding or withdrawal of life-sustaining procedures.

SECTION 4. No person shall be under any legal duty to participate in withholding or withdrawing of life-sustaining procedures authorized under this act.

SECTION 5. A physician acting in accordance with the provision of this act shall not be guilty of any criminal offense.

A physician acting in accordance with the provisions of this act shall not be subject to civil liability.
A physician acting in accordance with the provisions of this act shall not be deemed in breach of any professional oath or affirmation.

SECTION 6. A physician who withholds or withdraws life-sustaining procedures from a qualified patient, but fails to act in accordance with the provisions of this act shall be subject to punishment of a fine of an amount not exceeding $5,000 and/or suspension of his license to practice up to one year, and/or imprisonment for a period not exceeding one year. In addition, the physician will be deemed not to have acted in a unprivileged way for the purpose of civil liability.

A physician who withholds or withdraws life-sustaining procedures from a non-qualified patient and thereby hastens the patient's death shall be subject to prosecution for unlawful homicide.

The effect of this statute would be to legalize involuntary passive euthanasia in the form of withholding or withdrawing life-sustaining procedures from those patients suffering from severe cerebral cortex brain damage. This type of patient, according to the New Jersey Supreme Court, falls within the Quinlan standard—a patient whose life the state has no compelling interest to preserve. The statute has two major procedural safeguards: (1) a certification in writing by two physicians of the patient's condition and the efforts taken to treat the patient, and (2) a judicial hearing to determine the medical status of the patient.

Finally, the statute provides severe penalties for failing to follow the provisions of the act. Having been provided with the legal means and guidelines to terminate treatment, a physician who fails to follow the procedures must be held liable. It will be necessary for prosecuting authorities to police activities of physicians in order to deter any violations. After the practice has been legalized, the prosecuting authorities might be able to receive aid in deterring any violations by requesting support from the American Medical Association. In addition, a jury armed with the knowledge that a physician has had a reasonable opportunity to proceed under this type of statute, but failed to do so, is more likely to convict.

100. See text accompanying notes 88-95 supra. For additional constitutional considerations of such a statute, see Comment, Euthanasia: Criminal, Tort, Constitutional And Legislative Considerations, 48 NOTRE DAME LAW. 1202 (1973).
CONCLUSION

The medical community has embarked upon the widespread practice of involuntary passive euthanasia of brain-stem-damaged patients. The legal system in effect has relinquished the decision-making role to the attending physician. Unfortunately, the attending physician has no standards to guide him in his decision-making process. The practice under these circumstances is susceptible to mistake or abuse. If our society wants to protect itself against the possible premature killing of patients, it must establish new legal standards which will effectively regulate the practice of involuntary passive euthanasia among brain-damaged patients.

Daniel Mark Mueller
APPENDIX A

DIRECTIVE TO PHYSICIANS

Directive made this _______ day of _________ (month, year). I _________, being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death, and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by ______, M.D., whose address is ______, and whose telephone number is ______. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

5. This directive shall have no force or effect five years from the date filled in above.

6. I understand the full import of this directive, and I am emotionally and mentally competent to make this directive.

Signed ____________________________

City, County and State of Residence ____________________________
The declarant has been personally known to me, and I believe him or her to be of sound mind.

Witness ____________________________
Witness ____________________________