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By the time this article is published, the United States Supreme Court will likely have rendered its decisions in *Vacco v. Quill*¹ and *Washington v. Glucksberg*.² Many predict that those decisions will reverse the Circuit Courts of Appeals for the Ninth and Second Circuits and will reinstate the New York and Washington assisted suicide statutes which those courts had held unconstitutional under the Due Process and Equal Protection clauses of the Fourteenth Amendment. Some observers suggest that such a result will confirm the view that the question of whether and how physician-assisted suicide is to be legalized should be left exclusively to state legislatures and that courts, in particular, have no proper role to play with respect to this issue. This is a mistaken view which rests upon a simplistic notion of the roles played by the various branches of government in the American law-making process.

Courts and legislatures each have their strengths and weaknesses as law-making bodies. Indeed, the very qualities that constitute their respective strengths often constitute their respective weaknesses as well. For example, it is both an advantage and a disadvantage of court-made common law that it cannot rely for its validity upon a vote by the people's elected representatives. Judges who make law must, in support of their adopted principles, demonstrate a better justification than mere majority approval of the outcome of the case. Moreover, since judge-made law, unlike legislation, applies retroactively, the court must convince the reader that its rule of law is so reasonable that it can, with justice, be applied after the fact.

Another strength and weakness of judge-made law is that it is made in the context of individual cases. This restricts the generality

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of the rules that are developed, and requires law-making to await the development of cases that force courts to make law as part of the dispute resolution process. Case by case law-making also means that the judge makes law in a context which forces upon him a close acquaintance with the consequences of his action. Whereas the legislator is like the B-52 pilot who drops his bombs on the Mekong Delta and returns to a meal at his base in Japan, the judge is like the dog soldier who must look the enemy in the eye before he shoots him. The judge fashions the law in order to do justice in the case before him. The common law doctrine which develops out of this process attempts to generalize case law principles which lay claim to having produced the just result in each case. Conveniently, when such principles are later found unjust, they can be distinguished or overruled. Certainly many judges, lawyers, and commentators have come to think of the common law development process as one in which the "law work[s] itself pure from case to case."3 Sometimes, they have had difficulty accepting the incursion of seemingly arbitrary legislation into the law-making process. Where the legislation has seemed extraordinarily unjust, courts have sometimes declared it to be in violation of "fundamental law"—even where there were no written constitutions to supply such fundamental law. For example, Lord Coke's action in Bonham's Case,4 struck down an act of Parliament on the ground that a law "against common right and reason" is void.

Of course, legislative law-making has its virtues. The legislator, unlike the judge, need not wait for a dispute to arise before making law, and the law that is made can be as general in application and as detailed as the law maker wishes it to be. Additionally, the legislator need not restrict his decision-making to the available evidence which has been produced in a court of law by parties to a case. He can hear from any person or group that is interested in the outcome of his deliberations, and the law he ultimately produces can precisely accommodate whatever compromises have been struck between contending interest groups—it need be justified on no other basis than the fact that a majority has voted for it. Finally, the process of direct election of legislators is intended to provide the electorate with an opportunity to be ruled by the laws they really want rather than the laws that judges have chosen for them. In

4. See J. H. BAKER, AN INTRODUCTION TO ENGLISH LEGAL HISTORY 241 (3d ed. 1990) for a discussion of this case.
theory at least, the legislator who does not vote for the laws that the voters want will be removed from office at the next election.

Both courts and legislatures have played important roles in the development of contemporary American law regarding the "right to die," but many of the most significant first steps were taken by the courts. When, in 1975, Joseph Quinlan approached his daughter Karen's physicians with a request that she be taken off artificial life-support so as to allow her to die with dignity, the physicians were quite understandably concerned that they might expose themselves to criminal prosecution if they acceded to the request. Long-standing New Jersey statutes regarding both homicide and "Aiding Suicide" seemed potentially applicable to physicians who, by removing a ventilator from a patient, knowingly allowed the patient to die—even when that patient was in a persistent vegetative state. Mr. Quinlan and Karen's physicians might have approached the legislature and asked that these statutes be amended to create exceptions for cases like Karen Quinlan's. Had they done so, it is doubtful that the request would have been granted. New Jersey legislators would properly have feared that such amendments would have had the potential for legalizing much more than the removal of ventilators in cases like Karen Quinlan's. Legislation is written in sweepingly general terms and does not arise within the limiting context of the facts of a particular dispute. Moreover, New Jersey legislators would likely have been wary of the political consequences of voting for legislation that openly legalized certain acts of physician homicide and assisted suicide. Unless legislators were sure that the measure was popular, and that it did not have numerous opponents among the electorate who would be more willing than its proponents to reelect legislators on the basis of where they stood on that measure alone, the legislature would probably have refused to act.

Instead of applying to the legislature, Mr. Quinlan applied to the New Jersey courts. The courts ultimately granted the relief he requested. Despite the fact that the New Jersey Attorney General and the Morris County Prosecutor took the position that causing the death of Karen Quinlan by removing her from a ventilator would be a criminal act of homicide or aiding suicide, the Supreme Court of New Jersey determined that the act could be performed without fear of prosecution. Concluding that Karen Quinlan's

“right to privacy” under both the New Jersey State Constitution and the United States Constitution protected a decision to die with dignity rather than be maintained in a persistent vegetative state, the court decided that the State’s countervailing interest in “the preservation and sanctity of human life” did not outweigh Karen’s right on the facts of her case. “We have no hesitancy in deciding [in the instant case],” said the court, “that no external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life.”

Clearly, the court was moved by the plight of Karen Quinlan and her family, and was convinced that the law should permit them the relief they requested despite the lack of legislative sanction. The court was also moved to act by a desire to assist the medical profession. “[T]here must be a way,” the court said, “to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients.” Toward that end, the court laid down a procedure for insulating physicians from liability in cases like Karen’s in the future. Where the family, guardian, and physician of a patient in a permanent vegetative state agreed that the patient should be taken off life support, and a hospital “Ethics Committee” agreed that there was no reasonable possibility of the patient returning to a cognitive, sapient state, the life support could be withdrawn “without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.”

In the following year, the Supreme Judicial Court of Massachusetts rendered a decision that built upon the doctrinal base laid in Quinlan. In Superintendent of Belchertown State School v. Saikewicz, the Supreme Judicial Court granted relief to physicians at a state institution for the mentally retarded who sought permission to withhold from a profoundly retarded cancer patient a course of chemotherapy which they believed to be inhumane and pointless. Once again the court was moved to take action by the plight of the patient in the particular case and that of the medical profession in general. The court wanted to protect Mr. Saikewicz from being physically forced to endure the painful treatment that he would not

8. Id. at 668.
9. Id. at 672.
understand, and which would cause unpleasant and debilitating side-effects while offering him only, at best, the chance of a few additional months of life. The court also wanted to establish "a framework in the law on which the activities of health care personnel and other persons can find support."\(^{11}\) Like the New Jersey Supreme Court, the Supreme Judicial Court of Massachusetts based its decision on the constitutional right to privacy which, according to the court, "encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances."\(^{12}\) However, the court then made an effort to develop the law of the right to die beyond the point to which it had been taken in \textit{Quinlan}.

First, the court made an attempt to generalize the principles that it was applying beyond the narrow facts of cases involving patients in a persistent vegetative state or terminally-ill cancer patients. It did this by first delineating four State interests which, in every instance, were to be weighed against the patient's right to privacy in determining whether the patient had a right to die under the circumstances of the case.\(^{13}\) These were identified state interests in a) protecting innocent third parties (such as dependent children), b) preventing suicide, c) protecting the ethical integrity of the medical profession, and d) preserving human life.\(^{14}\) The last of these, the court stated, deserved the greatest consideration.\(^{15}\) But it was to be given much reduced weight in any case, such as the one before the court, where the question was not one of saving life but merely prolonging it.\(^{16}\)

The interest of the State in prolonging a life, must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended.\(^{17}\)

Second, the court developed a significantly different process from the one in \textit{Quinlan} for protecting the rights of incompetent

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11. \textit{Id.} at 422.
12. \textit{Id.} at 424.
14. \textit{See id.}
15. \textit{See id.} at 425.
17. \textit{Id.}
patients. Rather than merely delegating decision-making power to the patient’s guardian, family, and physician together with a hospital ethics committee, the Saikewicz court required that procedures be established for determining what the patient would have wanted for himself if he had been competent to make the decision. The court believed that

both the guardian ad litem in his recommendation and the judge in his decision should have attempted (as they did) to ascertain the incompetent person’s actual interests and preferences. In short, the decision in cases [involving incompetent patients] should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.18

The court, realizing that such a test presented special dangers, particularly in the case of a profoundly retarded patient, hastened to add: “[T]he chance of a longer life carries the same weight for Saikewicz as for any other person, the value of life under the law having no relation to intelligence or social position.”19 In order to make sure that the test was applied in a non-discriminatory fashion, the court determined that it should be administered by a court of law.20 The court reasoned that

such questions of life and death ... require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is [the court’s] responsibility . . . , and is not to be entrusted to any other group purporting to represent the “morality and conscience of our society,” no matter how highly motivated or impressively constituted.21

Over the next few years, the Massachusetts courts made significant additional progress in developing and refining principles of law in this area. In 1978, the Massachusetts Appeals Court rendered two noteworthy decisions. In Lane v. Candura,22 the court reversed a lower court’s finding that a seventy-seven year old widow suffering from gangrene of her right leg and foot was mentally incompe-

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18. Id. at 431.
19. Id.
20. See id. at 435.
21. Id.
tent to refuse an amputation that her doctors claimed was necessary to keep her alive.23 Since Mrs. Candura, unlike Mr. Saikewicz, was not terminally ill, the court had to deal with the issue of whether a patient had the right to refuse an amputation that could be classified as "life-saving" rather than merely "life-prolonging."24 Finding the Saikewicz distinction to be unworkable in the case before it, the court created new one based upon the "intrusiveness" of the proposed medical intervention:25

The . . . State interests [in] the preservation of life and the protection of the integrity of the medical profession, call for a balancing of those interests against the "strong interest [of the individual] in being free from nonconsensual invasion of his bodily integrity." The magnitude of the invasion proposed in this case is decisive in applying the balancing test.26

In the second 1978 case, In re Dinnerstein,27 the Appeals Court directed the lower court to rule that an attending physician could lawfully issue a do not resuscitate order for an incompetent patient despite the fact that there had been no court determination, as seemed to be required by Saikewicz, that the patient would have asked for such action to be taken if she had been competent to ask.28 Mrs. Dinnerstein suffered from Alzheimer's disease, was totally paralyzed on her left side, and was confined to a hospital bed in what the court called "an essentially vegetative state."29

She [was] fed through a naso-gastric tube, intravenous feeding having been abandoned because it came to cause her pain. It is probable that she [was] experiencing some discomfort from the naso-gastric tube, which [could have] cause[ed] irritation, ulceration, and infection in her throat and esophageal tract, and which [was] removed from time to time, and that procedure itself cause[d] discomfort. She [was] catheterized and also, of course, require[d] bowel care. Apart from her Alzheimer's disease and paralysis, she suffer[ed] from high blood pressure which [was] difficult to control; there [was] risk in lowering it due to a constriction in an artery leading to a kidney. She [had] a serious, life-threatening coronary artery disease, due to arteriosclerosis.

23. See id. at 1236.
24. See id. at 1233.
25. See id.
26. Id. at 1233 n.2 (emphasis added) (citations omitted).
28. See id. at 137-39.
29. Id. at 135.
Her condition [was] hopeless, but it [was] difficult to predict exactly when she [would] die. Her life expectancy [was] no more than a year, but she could go into cardiac or respiratory arrest at any time. One of these, or another stroke, [was] most likely to be the immediate cause of her death.30

In light of the utter hopelessness of Mrs. Dinnerstein’s condition and the highly intrusive nature of cardiopulmonary resuscitation, the court concluded that it was unnecessary for a court to determine what Mrs. Dinnerstein would have wanted for herself,31 because, according to the court,

[This] case [did] not . . . present, the type of significant treatment choice or election which, in light of sound medical advice, [was] to be made by the patient, if competent to do so. . . . This case [did] not offer a life-saving or life-prolonging treatment alternative within the meaning of the Saikewicz case. It presented a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient’s history and condition and the wishes of her family.32

In 1979, the Supreme Judicial Court had an opportunity to reconsider the life-prolonging versus life-saving treatment distinction it had employed in Saikewicz, and rejected it in favor of the intrusiveness standard of Candura and Dinnerstein. In Commissioner of Correction v. Myers,33 the court held that a prisoner who suffered total kidney failure could be compelled to submit to hemodialysis despite his protests. The court’s decision was justified on the basis that the State’s interest in preserving prison discipline outweighed Mr. Myers’ constitutional right to privacy.34 But, in passing, the court noted that, had Mr. Myers not been a prisoner, he would have had the right to prefer death over continued maintenance on dialysis,35 since

the State’s interest in the preservation of life does not invariably control the right to refuse treatment in cases of positive prognosis. For example, in Lane v. Candura, the Appeals Court upheld the right of a competent adult to refuse a leg amputation that would save, not merely prolong, her life. The decisive factor in

30. Id.
31. See id. at 139.
32. Id.
34. See id. at 458.
35. See id.
applying the balancing test in that case was the magnitude of the proposed invasion.36

Regarding the hemodialysis treatment the court concluded:

Unlike the relatively simple and risk-free treatments of supportive oral or intravenous medications, dialysis exacts a significant price from Myers in return for saving his life. In spite of the fact that dialysis does not require the sacrifice of a limb or entail substantial pain, it is a relatively complex procedure, which requires considerable commitment and endurance from the patient who must undergo the treatment three times a week.37

Although this statement was dictum in Myers, it was turned into a holding a year later in In re Spring,38 where the court determined that an incompetent patient could be removed from dialysis upon a showing that he would have requested removal if he had been competent.39

Thus, by small steps, the courts of Massachusetts were gradually broadening and refining the rights of patients to control their treatment in a medical setting, even when the exercise of that control would hasten death. In Saikewicz the exercise of that right had been restricted to situations where the patient faced imminent death, with or without treatment. In Candura, Myers, and Spring, it was extended to cases where the patient was not terminally ill, so long as the patient was refusing medical treatment which was properly labeled intrusive. Finally, in 1986, in Brophy v. New England Sinai Hospital,40 the Supreme Judicial Court extended the right to include any treatment which the patient deemed intrusive, even if others might not see it as objectively intrusive. Mr. Brophy, who was in a persistent vegetative state, had clearly expressed on many occasions, before he fell ill, that he would rather be dead than maintained on artificial life-support of any kind. He had once said to his brother: "If I'm ever like that, just shoot me. Pull the plug." In order to effectuate these wishes, Mrs. Brophy sought to have Mr. Brophy's G-tube removed in order to allow him to die of starvation or dehydration. The lower court had found that this was what Mr. Brophy would have wanted, but it did not think that his right to

36. Id. at 456-57 (citations omitted).
37. Id. at 457.
38. 405 N.E.2d 115 (Mass. 1980).
39. See id. at 119-23.
privacy entitled him to starve or dehydrate himself to death. The Supreme Judicial Court reversed on this latter point, and stated that

Brophy is not terminally ill nor in danger of imminent death from any underlying physical illness. . . . While the judge found that continued use of the G-tube is not a highly invasive or intrusive procedure and may not subject him to pain or suffering, he is left helpless and in a condition which Brophy has indicated he would consider to be degrading and without human dignity. In making this finding, it is clear that the judge failed to consider that Brophy's judgment would be that being maintained by use of the G-tube is indeed intrusive.41

A year before the decision in Brophy, the Supreme Court of New Jersey decided In re Conroy,42 its first "right to die" case since Quinlan. Claire Conroy was an incompetent eighty-four year old nursing home patient who was dependent upon a nasogastric tube for nourishment and hydration.43 "She suffered from arteriosclerotic heart disease, hypertension, and diabetes mellitus; her left leg was gangrenous . . . ; she had [bed sores] on her left foot, leg, and hip; an eye problem required irrigation; she ... could not control her bowels; she could not speak; and her ability to swallow was very limited."44 Because of her condition, Ms. Conroy's guardian (who was also her nearest relative) applied to the New Jersey courts to authorize the removal of her nasogastric tube so that her life would not be pointlessly prolonged.45 In an opinion which borrowed heavily from the Massachusetts decisions rendered since Quinlan, the Supreme Court of New Jersey held that Ms. Conroy, if competent, had the right to have the tube removed. Finding this right to be based in both the common law of informed consent and the constitutional right of privacy, the court weighed it against a list of countervailing State interests adopted from Saikewicz and held that none of the interests defeated Ms. Conroy's right to choose death, despite the fact that she was neither terminally-ill nor in a persistent vegetative state. In language which presaged the decision in Brophy, the court made clear that Ms. Conroy's right to refuse life-saving treatment could not be made conditional on other persons' views of the appropriateness of her decision. Accordingly, "[h]er interest in freedom from nonconsensual invasion of her bodily in-

41. Id. at 635-36.
42. 486 A.2d 1209 (N.J. 1985).
43. See id. at 1217.
44. Id.
45. See id. at 1218.
tegrity would outweigh any state interest in preserving life or in safeguarding the integrity of the medical profession."46 Indeed, the court stated that, "Ms. Conroy’s right to self-determination would not be affected by her medical condition or prognosis."47 Beyond that, the court stated that "a young, generally healthy person, if competent, has the same right to decline life-saving medical treatment as a competent elderly person who is terminally ill."48

However, Ms. Conroy was not competent, and the court was not comfortable with employing for her the proxy decision-making procedures it had used for Karen Quinlan.

The Quinlan decision dealt with a special category of patients: those in a chronic, persistent vegetative or comatose state. In a footnote, the opinion left open the question whether the principles it enunciated might be applicable to incompetent patients in "other types of terminal medical situations, . . . not necessarily involving the hopeless loss of cognitive or sapient life." We now are faced with one such situation: that of elderly, formerly competent nursing home residents who, unlike Karen Quinlan, are awake and conscious and can interact with their environment to a limited extent, but whose mental and physical functioning is severely and permanently impaired and whose life expectancy, even with the treatment, is relatively short.49

For such patients, the court adopted a version of the Massachusetts procedure for proxy decision-making. In reaching an acceptable decision on behalf of the incompetent patient, the court stated, "the goal of decision-making . . . should be to determine and effectuate, insofar as possible, the decision that the patient would have made if competent."50 In attempting to achieve that goal, all sources of evidence of the incompetent’s wishes should be consulted. A living will or durable power attorney for health care executed by the patient while competent—although not recognized as binding by New Jersey legislation—might be one valuable source. Other evidence such as oral statements, reactions that the patient voiced regarding medical treatment administered to others, and religious views all might bear on the question. "In this respect [the court] believe[d] that [it was] in error in Quinlan to disregard evidence of statements that Ms. Quinlan made to friends concerning artificial prolongation

46. Id. at 1226.
47. Id.
48. Id.
49. Id. at 1228-29 (citation omitted).
50. Id. at 1229.
of the lives of others who were terminally ill."

The court emphasized that the test was to be subjective. "The question is not," said the court, "what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself."

However, the court realized that in many cases there would not be sufficient evidence to make it "clear that the particular patient would have refused the treatment under the circumstances involved." So as not to "foreclose the possibility of humane actions, which may involve termination of life-sustaining treatment, for persons who never clearly expressed their desires about life-sustaining treatment," the court decided to offer two alternatives to its pure subjective test. Under one, the "limited-objective test," a patient in Ms. Conroy's situation could have life-sustaining treatment withheld or withdrawn where "there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him." Under the other, the "pure-objective test," a patient could be permitted to die without any showing of what the patient would have wanted. However, it would be necessary to prove that "the recurring, unavoidable and severe pain of the patient's life with the treatment [are] such that the effect of administering life-sustaining treatment would be inhumane" in addition to showing that the net burdens of the patient's life with the treatment clearly and markedly outweigh any benefits to him. Even under the pure-objective test, the court made clear that "life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain that he might experience."

At one point in its opinion, the court complained about being forced to fashion so much complicated law to fill the vacuum left by the legislature's failure to take action regarding the right to die in the nine years since *Quinlan*.

Perhaps it would be best if the Legislature formulated clear stan-

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51. *Id.* at 1230.
52. *Id.* at 1229.
53. *Id.*
54. *Id.* at 1231.
55. *Id.* at 1232.
56. *Id.*
57. *Id.*
pleading for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake. In addition, it has the resources and ability to synthesize vast quantities of data and opinions from a variety of fields and to formulate general guidelines that may be applicable to a broad range of situations.58

However, the court noted “[w]e have had the benefit of some legislation in this state concerning the rights of the institutionalized elderly,” including rules “directed to the protection of the civil and human rights of the elderly confined to long-term care facilities and similar institutions.”59 Among these rules was one enacted in 1983 that charged the state Office of the Ombudsman for the Institutionalized Elderly with responsibility for protecting institutionalized elderly patients from “abuse”—a term which was defined to include “wilful deprivation of services which are necessary to maintain a person’s physical or mental health.”60 This new provision, the court noted, creates “a vehicle for safeguarding the rights of elderly, institutionalized, incompetent patients both to receive medical treatment and to refuse life-sustaining medical treatment under certain circumstances.”61 The court availed itself of this vehicle by establishing a procedure for future cases in which life-sustaining treatment could not be withheld or withdrawn from an elderly, institutionalized, incompetent patient unless the Ombudsman had first determined that no abuse was taking place. This he was to do by investigating the situation and taking evidence from the attending physician and nurses, from the patient’s guardian and family, and from two independent physicians appointed for the purpose of confirming the patient’s medical condition and prognosis.

At the very end of the Conroy opinion, the court summed up its work by saying:

We have not attempted to set forth guidelines for decision-making with respect to life-sustaining treatment in a variety of other situations that are not currently before us. Innumerable variations are possible. However, each case—such as that of the severely deformed newborn, of the never-competent adult suffering from a painful and debilitating illness, and of the mentally

58. Id. at 1220-21 (footnote omitted).
61. Conroy, 486 A.2d at 1239.
alert quadriplegic who has given up on life—poses its own unique
difficulties. We do not deem it advisable to attempt to resolve all
such human dilemmas in the context of this case. It is preferable,
in our view, to move slowly and to gain experience in this highly
sensitive field. As we noted previously, the Legislature is better
equipped than we to develop and frame a comprehensive plan
for resolving these problems.62

By 1987, the New Jersey legislature still had not acted, and the
New Jersey Supreme Court was confronted with three more right to
die cases in which it was required to make law. “[T]hese three ap­
peals,” said the court, “concern the withdrawal of life-sustaining
treatment from three women suffering from incurable and irrevers­
ible medical conditions. Because of their ages, places of residence,
and medical conditions, none of their cases falls within the factual
pattern of either of our seminal decisions, Quinlan or Conroy.”63
The court recognized, as it did in Conroy, “and as have numerous
other courts, that given the fundamental societal questions that
must be resolved, the Legislature is the proper branch of govern­
ment to set guidelines in this area.”64

[Pa]tients and their families and physicians are increasingly being
faced with these difficult and complex decisions without legisla­
tive guidelines and under the threat of civil and criminal liability.
Until the Legislature acts, it is to the courts that the public must
look for the guidelines and procedures under which life-sus­
taining medical treatment may be withdrawn or withheld. Sensi­
tive to the patients’ rights to self-determination, but cognizant of
the vulnerability of the sick, [the courts] strive to protect all of
the relevant interests.65

In the first of the three cases, In re Farrell,66 the court estab­
lished principles and procedures for cases where competent patients
dying at home requested that their deaths be hastened through re­
moval of life-support. Kathleen Farrell was a thirty-four year old
woman who was dying at home of amyotrophic lateral sclerosis. In
November of 1985, “after an experimental program that her hus­
band characterized as ‘their last hope’ had failed, Mrs. Farrell told
him that she wanted to be disconnected from the respirator that

62. Id. at 1244.
64. Id. at 407 (citations omitted).
65. Id. at 408.
sustained her breathing."67 A consulting psychologist met with Mrs. Farrell and concluded that "Mrs. Farrell had made an informed, voluntary, and competent decision to remove the respirator."68 Nonetheless, because of doubts as to the legality of hastening Mrs. Farrell's death in this fashion, Mr. Farrell applied to the New Jersey courts for, among other things, "a declaratory judgment that he and anyone who assisted him in disconnecting her respirator would incur no civil or criminal liability."69 The Supreme Court of New Jersey held that the respirator could be removed without fear of liability so long as certain procedures were followed. First, it must be determined "that the patient is competent and properly informed about his or her prognosis, the alternative treatments available, and the risk involved in the withdrawal of the lifesustaining treatment . . . . [Furthermore] the patient [must make] his or her choice voluntarily and without coercion."70 Second, "the patient's right to choose to disconnect the life-sustaining apparatus must be balanced against the four potentially countervailing state interests [which we have discussed]. Generally, a competent informed patient's interest in freedom from nonconsensual invasion of her bodily integrity would outweigh any state interest."71 Third, in order to

In conclusion the court stated:

Unfortunately fears of civil and criminal liability have often forced family members or doctors to seek judicial intervention before they help a patient effectuate his or her decision to withdraw treatment. . . . In light of this, we specifically hold that no civil or criminal liability will be incurred by any person who, in good faith reliance on the procedures established in this opinion, withdraws life-sustaining treatment at the request of an informed and competent patient who has undergone the required in-

67. Id. at 408-09.
68. Id. at 409.
69. Id.
70. Id. at 413 (citation omitted).
71. Id.
72. Id. at 415.
dependent medical examination described above. 73

The remaining two cases, In re Peter 74 and In re Jobes, 75 were the first cases involving patients in a persistent vegetative state that the court had faced since their 1976 decision in Quinlan. The New Jersey Supreme Court saw them, among other things, as an opportunity to revisit and revise Quinlan in light of the law the court had developed in the intervening eleven years. In Jobes, the husband of a thirty-one year old PVS patient in a nursing home sought to enable the patient to die with dignity by disconnecting her from artificial nutrition and hydration. At trial, there was conflicting evidence as to whether Nancy Jobes was in fact in a persistent vegetative state. Two nursing home experts contended that she fell “slightly outside of their definition of the persistent vegetative state.” 76 After stating that Conroy had established the principle that “all medical determinations made in the course of a decision to withhold treatment from an incompetent patient [must] be based upon clear and convincing medical evidence,” the New Jersey Supreme Court concluded that the experts for Mr. Jobes had “offered sufficiently clear and convincing evidence to support the trial court’s finding that Mrs. Jobes is in an irreversible vegetative state.” 77 Thereafter, to deal with the question of the appropriateness of removing artificial nutrition and hydration in the circumstances of the case, the court developed a set of principles and procedures which was an amalgam of Quinlan and Conroy. Whereas Quinlan had delegated the withdrawal of treatment decision to a group of proxy decision-makers, Conroy had laid down a methodology for attempting to determine what decision the patient would have made for himself if the patient were competent. Relying upon Conroy, Mr. Jobes had introduced considerable evidence that his wife would have wished to be taken off life-support. The Supreme Court determined that Mr. Jobes had been correct in assuming that Conroy would have governed rather than Quinlan if Mr. Jobes had sufficient proof of Mrs. Jobes’ wishes. However, the court concluded that “although there is some ‘trustworthy’ evidence that Mrs. Jobes, if competent, would want the j-tube withdrawn, it is not sufficiently ‘clear and convincing’ to satisfy the subjective test.” 78

73. Id. at 415-16 (citations omitted).
74. 529 A.2d 419 (N.J. 1987).
75. 529 A.2d 434 (N.J. 1987).
76. Id. at 440-41.
77. Id. at 441.
78. Id. at 443 (citations omitted).
about life-support that were attributed to Mrs. Jobes were remote, general, spontaneous, and made in casual circumstances.\textsuperscript{79} The court then considered the applicability to Mrs. Jobes' case of Conroy's limited-objective and pure-objective tests. The court ruled that the tests were not applicable. Essential to the administration of those tests was a balancing of the actual burdens and benefits to an incompetent patient. But since there was no evidence that persons in a persistent vegetative state could feel either pleasure or pain, there were no burdens or benefits to be weighed. As a result, the court returned to the proxy decision-making procedure of Quinlan.

Where an irreversibly vegetative patient like Mrs. Jobes has not clearly expressed her intentions with respect to medical treatment, the Quinlan "substituted judgment" approach best accomplishes the goal of having the patient make her own decision. In most cases in which the "substituted judgment" doctrine is applied, the surrogate decisionmaker will be a family member or close friend of the patient. Generally it is the patient's family or other loved ones who support and care for the patient and who best understand the patient's personal values and beliefs. Hence they will be best able to make a substituted medical judgment for the patient.

Ideally, each person should set forth his or her intentions with respect to life-supporting treatment. This insures that the patient's own resolution of this extraordinarily personal issue will be honored. Failure to express one's intentions imposes an awesome and painful responsibility on the surrogate decisionmaker.\textsuperscript{80}

In light of the fact that the ability to set forth such intentions continued to be hampered by the legislature's continuing failure to enact living will or health care proxy legislation, the court concluded by saying: "As we have previously explained, the Legislature is better equipped than the judiciary to frame comprehensive guidelines and procedures for the withdrawal of life-sustaining treatment. Accordingly, we urge it to pass legislation in this area."\textsuperscript{81}

\textit{In re Peter},\textsuperscript{82} the third companion case, also dealt with a request to remove life-support from a patient in a persistent vegeta-

\textsuperscript{79} Id.
\textsuperscript{80} Id. at 451.
\textsuperscript{81} Id. at 452.
\textsuperscript{82} 529 A.2d 419 (N.J. 1987).
tive state. Its facts differed from those of *Jobes* in that Ms. Peter was a sixty-five year old nursing home resident, and she had left "clear and convincing evidence" of a desire to be taken off life-support if she were in a persistent vegetative state. Mrs. Jobes had been in a nursing home, but she was not elderly. Thus there was no need to involve the New Jersey Ombudsman procedure that had been laid down in *Conroy*. Because Ms. Peter was both in a nursing home and elderly, the court held that the Ombudsman had to be consulted to make sure that no abuse was taking place. The court reasoned:

We recognize that elderly nursing home patients in the persistent vegetative state are threatened by the same conditions that put patients like Claire Conroy at risk, *i.e.*, an uneven level of care, minimal medical supervision, and frequent lack of family support. Accordingly, the Ombudsman, in consonance with his statutory mandate, must be given the opportunity to investigate and prevent any possible mistreatment of elderly nursing home patients who have been declared to be in a persistent vegetative state.

With respect to the proof of Ms. Peter's wishes, the lower court had been presented with a durable power of attorney signed by Ms. Peter in which she authorized "Eberhard Johanning to make 'all medical decisions' for her and 'to be given full and complete authority to manage and direct her medical care.'" "Clearly the best evidence [of intent]," said the court,

is a "living will," a written statement that specifically explains the patient's preferences about life-sustaining treatment. Some states have statutes that recognize the validity of living wills and prescribe procedures for their execution. Unfortunately, the New Jersey Legislature has not enacted such a law. "Whether or not they are legally binding, however, such advance directives are relevant evidence of the patient's intent."

Hilda Peter had not left a living will, but she had executed a durable power of attorney.

New Jersey's Powers of Attorney statute provides that a "principal may confer authority on an agent that is to be exercisable

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83. See *id.* at 422.
84. *Id.* at 428-29 (citations omitted).
85. *Id.* at 426.
86. *Id.* (citations omitted).
87. See *id.*
notwithstanding later disability or incapacity of the principal at law or later uncertainty as to whether the principal is dead or alive." Although the statute does not specifically authorize conveyance of durable authority to make medical decisions, it should be interpreted that way.

It would have been better if Ms. Peter had specifically provided in her power of attorney that Mr. Johanning had authority to terminate life-sustaining treatment. Nonetheless, that instrument, which she executed shortly before she became incompetent; Mr. Johanning's explanation that Ms. Peter directed him to refuse life-sustaining treatment on her behalf in a situation like this; and nine reliable hearsay accounts of her disinclination for the kind of treatment that Mr. Johanning seeks to discontinue establish clearly and convincingly that Hilda Peter would, if competent, choose to withdraw the nasogastric tube that is sustaining her.88

In 1991, the New Jersey State Legislature finally enacted legislation providing for "advance directives for health care."89 But, until that time, the law of the right to die in New Jersey was governed entirely by principles and procedures developed by New Jersey courts, out of decisions in cases that cried out for recognition of a right to die on the facts presented. At each step along the way, the New Jersey Supreme Court described itself as being forced to act, at least in part, in the face of legislature's failure to do so—going so far as to establish, on its own authority, the legality of living wills and durable powers of attorney for health care. In Massachusetts, the state legislature ultimately passed legislation which authorized the execution of formal documents to appoint a health care proxy,90 but living wills are still given recognition in Massachusetts only under the State's right to die case law.91 Even in states where comprehensive right to die legislation has been enacted, courts have been required to fashion common law as part of the comprehensive package of rules governing the right to die.

California was the first state to pass living will legislation. Its Natural Death Act92 was passed in 1976. Nonetheless, in 1983, when murder charges were brought against two California physicians who had removed life-support from a patient in a vegetative

88. Id. at 426-27 (footnotes and citations omitted).
state, the California courts were forced to create a new rule of law in order to achieve what they believed to be the just result. In *Barber v. Superior Court*, the California Court of Appeals dismissed the murder charges on the ground that the law had not required the physicians to provide artificial life-support to the patient after such treatment became "disproportionate in terms of the benefits to be gained versus the burdens caused." This principle was not one which the court could derive from the state's legislation. The State's Uniform Determination of Death Act related only to situations where a patient's "whole brain" was no longer functioning, and patients in a persistent vegetative state retained lower brain function. The State's Natural Death Act dealt only with situations where patients had executed living wills to direct how they were to be treated after they lost competence. The patient in *Barber* had executed no living will; but the patient's physicians had determined that he had no reasonable chance of returning to a cognitive state. Additionally, the patient's relatives had requested in writing that he be taken off artificial food and hydration. The court said that the only long-term solution to this problem is necessarily legislative in nature. It is that body which must address the moral, social, ethical, medical and legal issues raised by cases such as the one at bench. Manifestly, this court cannot attempt to rewrite the statutory definition of death or set forth guidelines covering all possible future cases. Due to legislative inaction in this area, however, we are forced to evaluate petitioner's conduct within the context of the woefully inadequate framework of the criminal law.

The court found the starting point for its solution in the common law of informed consent, which "clearly recognized [a] legal right to control one's own medical treatment [that] predated the Natural Death Act." Citing to, among others, the Massachusetts and New Jersey cases dealing with the right to die, the court held that the common law right to control one's medical treatment included the right to refuse life-prolonging treatment where such treatment becomes "disproportionate." "Under this approach, proportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which

94. *Id.* at 1019.
95. [CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1997)].
96. *Barber*, 147 Cal. App. 3d at 1014.
97. *Id.* at 1015.
benefits outweigh the burdens attendant to the treatment. But what should be done where the patient is no longer competent to express his views and has not executed a living will? As to patients in a persistent vegetative state, the court developed an approach that was an amalgam of the tacks taken in the New Jersey and Massachusetts cases. Quoting first from Quinlan, the court said: "[T]he focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence . . . ." Then quoting from Dinnerstein, the court said: "Prolongation of life, . . . does not mean a mere suspension of the act of dying, but contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence." Finally, citing to Saikewicz, the court said: "The authorities are in agreement that any surrogate, court appointed or otherwise, ought to be guided in his or her decisions first by his knowledge of the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent." The court said if that is not possible, the surrogate ought to be guided in his decision by the patient's best interests. Under this standard, such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as extent of life sustained may be considered. Finally, since most people are concerned about the well-being of their loved ones, the surrogate may take into account the impact of the decision on those people closest to the patient.

The court noted that

[i]f specific procedural rules are to be adopted in this area in order to protect the public interest, they must necessarily come from that body most suited for the collection of data and the reaching of a consensus—the Legislature. However, we would [have been] derelict in our duties if we [had] not provide[d] some general guidelines for future conduct in the absence of such legislation.

A Connecticut case, McConnell v. Beverly Enterprises-Con-
necticut, Inc., provides an illustration of the role that courts can play in developing common law even where State legislatures have provided specific procedural and substantive rules for the removal of life-support systems. In 1985, the Connecticut State Legislature enacted a provision called the Removal of Life Support Systems Act. It provided: “Any physician licensed under chapter 370 or any licensed medical facility which removes or causes the removal of a life support system of an incompetent patient shall not be liable for damages in any civil action or subject to prosecution in any criminal proceeding for such removal” so long as 1) the patient is terminally ill, and 2) the decision is based upon a) “the best medical judgment of the attending physician,” b) “the informed consent of the next of kin, if known, or legal guardian,” and c) “the patient’s wishes as expressed by the patient directly, through his next of kin or legal guardian, or in the form of a document executed in accordance with [this act].” The term “Life Support System,” as used in the statute, included “any mechanical or electronic device,” but excluded “the provision of nutrition and hydration.” Thus, when John McConnell sought to have a gastrostomy tube removed from his wife so that she could die with dignity rather than continue to live in a persistent vegetative state, the statute seemed to preclude granting him the relief he requested. What he was asking for was cessation of the provision of nutrition and hydration.

Mrs. McConnell was a fifty-seven year old nurse who had worked in emergency medicine up until the time of the accident which had rendered her comatose. “[B]ecause of her professional training and experience,” the court found,

Mrs. McConnell understood the status of patients with traumatic brain damage and was fully familiar with all forms of life-sustaining equipment, including respirators and gastrostomy tubes. She had, in fact, expressly and repeatedly told her family and her co-workers that, in the event of her permanent total incapacity, she did not want to be kept alive by any artificial means, including life-sustaining feeding tubes.

Despite the clear language of The Removal of Life Support Sys-

104. 553 A.2d 596 (Conn. 1989).
106. Id. at § 19a-571(a) (amended 1991).
107. Id.
108. Id.
109. Id. at § 19a-570 (emphasis added).
tems Act, all of the judges who dealt with the case determined that Mrs. McConnell had a right to remove the gastrostomy tube. At the trial level, the court justified the result on Mrs. McConnell's "common law right to self-determination, supported by a constitutional right to privacy" which coexisted with the statutory provisions "by which the legislature authorized the removal of life support systems under statutorily specified circumstances." On appeal, Associate Justice Healey would have affirmed on this ground. "I believe that the statutory scheme did not entirely displace the common law," he said.

"It is an established rule of statutory construction that statutes are not readily interpreted as abrogating common-law rights." It is also a rule of statutory construction that statutes in derogation of the common law are strictly construed. "No statute is to be construed as altering the common law farther than its words import. It is not to be construed as making any innovation upon the common law which it does not fairly express."

The exclusion of "the provision of nutrition and hydration" from the definition of "life support system" strongly suggests a legislative intent to address only the withdrawal of "any mechanical or electronic device from a terminal patient." The exclusion does not suggest an intent to displace the common law right to self-determination of one's bodily integrity as it pertains to the withdrawal of other medical treatment, including extraordinary means of nutrition and hydration.

But a majority of the court felt obligated to decide the case by applying the statute to the facts of the case. "Many of the cases upholding a right of self-determination for terminally-ill individuals have urged legislatures to enact guidelines for appropriate private decision-making in these heart-rending dilemmas," noted the majority opinion. "When the legislature has attempted to respond to this urgent request for statutory assistance, we have an obligation to pursue the applicability of statutory criteria before resorting to an exploration of residual common law rights, if any such rights indeed remain." The court then went on to interpret the statute to permit withdrawal of artificial nutrition and hydration. It held that the exclusion of the provision of "nutrition and hydration" from the definition of "life support systems" that could be removed from ter-

111. Id. at 599.
112. Id. at 606-07 (Healey, J., concurring) (citations omitted).
113. Id. at 602 (citations omitted).
minally ill patients was meant to apply only to spoon feeding and water provided by mouth. The court agreed that it made sense to recognize a . . . distinction between artificial technology to assist nutrition and hydration, a fortiori included within the definition of a “life support system,” and normal procedures to assist in feeding. In other words, the act, read in its entirety and giving effect to every section[,] implicitly contemplates the possible removal from a terminally ill patient of artificial technology in the form of a device such as a gastrostomy tube, but it does not, under any circumstances, permit the withholding of normal nutritional aids such as a spoon or a straw.114

“Our construction of the act,” said the court, “implements its beneficent purpose of providing functional guidelines for the exercise of the common law and constitutional rights of self-determination that, as we have noted above, have received almost universal recognition.”115 It also, as the court pointed out, provided an interpretation that would save the statute from any constitutional attack. The court said that

[T]he plaintiffs in the case have indeed raised such a constitutional claim. We need not, however, address this claim on its merits when we can instead find redress for the plaintiffs by an appropriate construction of the applicable statutes. Established wisdom counsels us to exercise “self-restraint” so as “to eschew unnecessary determinations of constitutional questions.” It is, nonetheless, relevant to our construction of the statutory exclusion that our interpretation avoids placing the Removal of Life Support Systems Act in constitutional jeopardy.116

Obviously, common law courts have played an enormous role in the development of the law of the right to die. But this is not to say that State legislatures have not played an important role as well. By 1994, forty-seven states had enacted some form of living will legislation.117 Like the California Natural Death Act of 1976, they provided competent individuals with an opportunity to execute formal advance directives instructing physicians and family as to their wishes regarding life-prolonging treatment. Over the years, several national organizations have promoted “model” forms of such legis-

114. Id. at 602-03 (citations and footnotes omitted).
115. Id. at 603.
116. Id. at 603-04 (citations omitted).
lation, and the legislation that has been enacted has tended to be based upon a small number of types. But in detail, the legislation tends to be very variegated—evidencing the fact that different compromises have been worked out in different States over the fundamental value issues involved. Additionally, the legislation has tended to be amended frequently as new issues have arisen and new majorities have formed around them. For example, many of the earliest living will statutes authorized decisions only for patients who were "terminally ill" (typically defined as someone who had only six months to live). By 1994, the vast majority of living will statutes no longer contained such restrictions, and many of them had been amended to authorize decisions for patients in a permanent vegetative state who might live on for decades. On the other hand, some of the early restrictions have persisted. For example, living will statutes in thirty-four States explicitly refuse authorizing withdrawal of life-prolonging treatment from pregnant patients.

A second wave of statutes regulating refusal of life prolonging treatment for incompetent patients took a different approach—that of allowing the patient to appoint a "health care agent." These statutes empowered the patient to execute a formal document appointing another person to make a health care decision for him if the patient were to become incompetent. Proponents believed this to be a much more effective way to assure that physicians would respect patient autonomy. At a time when the patient could not assert his own rights, the physician would not be left with a mere piece of paper containing necessarily vague statements about the patient's feelings regarding "death with dignity." Instead, the physician would receive direction from an agent who had been picked by the patient because the agent knew the patient well enough to assert his rights for him. Such legislation quickly received widespread acceptance. By 1994, all but one state had enacted some form of health care agency legislation. As with living will legislation, the basic types of such legislation have been few, but there have been differences in detail—some of it reflecting different com-

121. See State Statutes Governing Living Wills and Appointment of Health Care Agents, in RIGHT TO DIE LAW DIGEST, supra note 119.
promises reached in different states over fundamental value issues.\textsuperscript{122} On the other hand, whether simply because the health care agency acts have been more recently passed or because of other reasons, such acts tend to have fewer "ethical restrictions" associated with them than do the living will acts. For example, only fourteen states have pregnancy restrictions in their health care agency statutes as opposed to thirty-four which have them in their living will statutes.\textsuperscript{123}

Of course, living will and health care agency statutes regulate decision-making for incompetent patients only where the incompetent patient was competent at some point in his life and had the foresight to execute the formal documents required for taking advantage of the laws. Many cases, such as \textit{Saikewicz}, involve patients who have never been competent. Moreover, despite great efforts to urge citizens to write living wills or appoint health care agents, the vast majority of Americans do not do so. The Patient Self Determination Act of 1991\textsuperscript{124}—the only piece of legislation passed thus far by the U.S. Congress dealing with the right to die—requires all medical facilities receiving federal funds to inform patients of living will and health care agency laws in their state, and to make available the forms needed for taking advantage of them. Unfortunately, these efforts have not made a significant increase in the number of patients availing themselves of those options. Since polls indicate that the vast majority of persons do wish a "death with dignity" for themselves and do not want extraordinary measures taken to keep them technically "alive,"\textsuperscript{125} it does not seem that they are failing to take advantage of the laws because they are opposed to having termination of care decisions made for them. Thus, the question remains of what to do with terminally-ill patients who become incompetent without having exercised any of these statutory options as well as with those who have always been incompetent.

As of June 1994, twenty-four states had dealt with the first of these problems by enacting "surrogate decision-making" statutes that appoint a health care agent for a patient if he does not appoint

\textsuperscript{122} See \textit{Artificial Nutrition and Hydration in Living Will Statutes}, in \textit{Right to Die Law Digest}, supra note 119.


\textsuperscript{124} 42 U.S.C.A. § 1395cc(f) (West Supp. 1997).

one for himself. Again displaying interesting differences in detail from state to state, these statutes typically appoint, in order of descending preference, the sorts of family members that the patient would be thought most likely to pick for himself. For example, the first choice might be one's spouse (unless legally separated from the patient), the second choice, one's adult children, the third, one's parents, the fourth, one's siblings, etc. These statutes operate much the same way as intestacy laws which arrange for the inheritance of one's property by statutorily-selected heirs in cases where the deceased has never executed a will. The patient can avoid having the choice made for him in this way by appointing a different person under the state's health care agency statute. The surrogate decision-making statutes typically provide the patient with another option as well—that of refusing to have any surrogate appointed for him on the ground that the patient does not want anyone empowered to refuse any medical options that might be available to him.

Despite all of the statutes that have been passed over the last twenty-five years, families of patients, physicians, and ultimately the courts, still find themselves confronted with cases in which procedures for proxy decision-making for incompetents have not been spelled out. Most importantly, twenty-six states do not have statutes providing for the appointment of surrogate decision-makers in the absence of execution of a living will or formal selection of an agent by a patient. In addition, there are situations which are excluded from coverage by statutes, such as decision-making for neonates and other patients who have never been competent. The state courts have continued to show a great deal of thought and creativity in fashioning procedures for dealing with such situations. Moreover, the courts have been busy creatively interpreting and applying the legislation that has been passed, sometimes providing liberal interpretations to conservative statutes as we saw done in McConnell v. Beverly Enterprises-Connecticut, Inc.

As the Supreme Court of the United States recognized in Cruzan v. Director, Missouri Department of Public Health, the development of the law of the right to die in the United States has been managed almost entirely at the state level in a fashion which has engaged courts and legislatures in a cooperative enterprise.

127. See id. at 3.
129. The Supreme Court reflected that
The state supreme courts in particular have taken on the law-making challenges offered by the technological developments of late twentieth century America. This has been done in a fashion that is reminiscent of the work of the state supreme courts of the “Golden Age of American Jurisprudence”—the mid-nineteenth century period when the state courts were forced to fashion new rules of law to deal with the development of the railroads, the telephone, the telegraph, the modern mass-production factory, and the corporate form of doing business. One reason for the successful operation of this cooperative effort between courts and legislatures is that in the area of the right to die, unlike that of the right to choose abortion, the Supreme Court of the United States has not handed down a rigid national constitutional standard which chills experimentation in devising differing legal responses to the problem. In *Roe v. Wade*, the Supreme Court used the constitutional right to privacy to essentially write for all of the fifty states the most liberal abortion statute in the Western World. The constitutional doctrine developed by the United States Supreme Court and the state supreme courts in the area of the right to die has left much more latitude for experimentation by means of common law and legislation. In *Cruzan*, the United States Supreme Court’s one pronouncement on the subject thus far, the Court recognized in passing that competent patients were possessed of a “constitutionally protected right to refuse lifesaving hydration and nutrition,” but it held that the state of Missouri could constitutionally burden that right by imposing a requirement that the patient’s intent to exercise that right must be proved by no less than “clear and convincing evidence.” The various state supreme courts that have bottomed the right to die on various provisions of their state constitutions and the federal constitution have, as we saw, continually urged the state legislatures to develop comprehensive rules for dealing with the issues that were raised. Indeed, as time has passed, the state supreme courts have

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As these cases demonstrate, the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these decisions demonstrate both similarity and diversity in their approach to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones. State courts have available to them for decision a number of sources—state constitutions, statutes, and common law—which are not available to us.

*Id.* at 277.


132. *Id.* at 280.
emphasized the constitutional aspects less and have used state common law increasingly—in part, presumably, to provide a greater scope of experimentation for state legislatures. The New Jersey Supreme Court, for example, beginning with Conroy, has relied primarily upon the common law principles of informed consent, and only secondarily upon the constitutional right to privacy. "The doctrine of informed consent, said the court, "is a primary means developed in the law to protect [the] personal interest in the integrity of one's [own] body." The court then added: "The right to make certain decisions concerning one's body is also protected by the federal constitutional right of privacy." Two years later, Farrell reaffirmed this aspect of Conroy: "[There] we held," said the court, "that a patient's right to refuse medical treatment even at the risk of personal injury or death is primarily protected by the common law, [although] we recognized that it is also protected by the federal and state constitutional right of privacy." 

The sort of conversation and cooperation between the common law courts and the state legislatures, that has aided the development of the law of right to die thus far, has much to offer to the development of right to die law in the future. It is simplistic to think that the law of physician-assisted suicide should be developed by only one or the other of these law-making institutions. Of course, legislative legalization of physician-assisted suicide might bring with it many of the virtues which were claimed for legislative law-making in general at the beginning of this article. Last year, eight co-authors and I proposed A Model State Act to Authorize and Regulate Physician-Assisted Suicide for the purpose of expediting the passage of such legislation. Several state legislatures are considering versions of the model act. But the fears that have kept state legislatures from leading the way in developing the right to die law in the past still seem to haunt the corridors of our legislative assemblies. Oregon, has thus far been the only state to legalize physician-assisted suicide by legislation, and that law was enacted through a citizen initiative vote—not by the normal legislative process. Indeed, now that the Oregon law seems on the threshold of

134. Id.
In the meantime, state courts have continued to press forward in developing right to die law on a case by case basis. On January 1, 1997, a trial court in Palm Beach Florida rendered its much-anticipated decision in McIver v. Krischer. The case involved a petition by a physician, Cecil McIver, and a patient, Charles Hall, who requested declaratory and injunctive relief which would protect Dr. McIver from prosecution should he choose to assist Mr. Hall in committing suicide by means of a lethal prescription of drugs. Charles Hall was terminally ill with AIDS, suffered from a long list of related illnesses, and "testified that he, at times, [had] sores over his entire body, red blotches, sores in and about his mouth, fine hairs on his tongue and sides of his mouth, no feeling in his bladder, stomach pains, and [was] legally blind." He also testified that,

[contemplating his future suffering, he want[ed] to die at the time and place of his choosing by administering a substance which would induce immediate loss of consciousness and certain death shortly thereafter. Yet, he [was] afraid that any attempt to take his own life at that time [would] be unsuccessful, and [would] worsen his condition. Therefore, Mr. Hall [had] sought consultation with an assistance of a physician to provide him with a prescription for a drug that Mr. Hall would self-administer to precipitate his instant death when he reache[d] the point where he [was] convinced that his only alternative [was] to experience a prolonged period of useless suffering."

As to Dr. McIver, the court found that

[He was] willing to exercise his professional skill and judgment to consult with Mr. Hall and provide him with the assistance he request[ed] to induce his death. Dr. McIver [had] examined and consulted with Mr. Hall and concluded that he was fully competent at all relevant times to make the request he [was] making, and that his decision [was] not the result of mental illness or undue influence by others.

138. The Oregon Death with Dignity Act was enjoined before going into effect. See Lee v. Oregon, 869 F. Supp. 1491 (D. Or. 1994). On Appeal, the injunction was removed. See Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997).
139. See, e.g., Foes of Assisted Suicide Lobby Senators, EUGENE REGISTGUR-GUARD, May 28, 1997, at 3D.
141. Id. at 3.
142. Id. at 2-3.
Dr. McIver's professional judgment [was] that it would be medically appropriate and ethical to provide Mr. Hall with the assistance he [had] request[ed] at some time in the near future. However, Dr. McIver testified he [would] not provide Mr. Hall with the assistance Mr. Hall request[ed] because of his fear of prosecution by the State Attorney for "assisting self-murder."143

Faced with such compelling facts, the court granted the declaratory and injunctive relief which was requested. In doing so, it took full advantage of the ability of a court (as compared with a legislature) to restrict its law-making to the facts of the case before it. "Realizing that the matter before the court is one of first impression and of public interest," the court said,

it is emphasized that the findings, decision, and direction in this cause relate to these parties only—Mr. Hall, an adult, who is mentally competent, terminally ill with AIDS, facing a certain and agonizing death, and being under no influence, and Dr. McIver, who is willing to assist Mr. Hall under the circumstances of this case. Although Dr. McIver, under this court's order, has the right without fear of prosecution, to assist Mr. Hall, he cannot be compelled to do so.144

On the other hand, in reaching its conclusion, the court made important new law regarding physician-assisted suicide. Florida's Privacy Amendment,145 which had been added to the State Constitution in 1980, was held to extend constitutional protection to prescription of lethal dosages of drugs for the purpose of achieving physician-assistance in suicide. "Suicide," said the court,

may be defined as the premature ending of one's life, therefore, in the strictest sense, disconnection from life support or withholding of food and water are all forms of suicide. However, suicide by the terminally ill by their refusal of life supporting or sustaining treatment is constitutionally protected, while it is argued that suicide with the assistance of a physician through the introduction of a death producing agent is not. Physicians are permitted to assist their terminal patients by disconnecting life support or by prescribing medication to ease their starvation. Yet, medication to produce a quick death, free of pain and protracted agony, are prohibited. This is a difference without a distinction. In those cases where a competent, terminal patient chooses to hasten his death the State has little interest in preventing this

143. Id. at 4.
144. Id. at 11.
145. FLA. CONST. art. I, § 23.
type of suicide. It is clear that the State has little reason in forcing the prolongation of Mr. Hall’s pain and suffering merely because he takes medication to shorten his death instead of taking medication to ease a longer dying period. The State’s legitimate concern cannot override Mr. Hall’s interest in foreshortening his existence by mere days.146

_McIver_ is presently on appeal to the Florida Supreme Court, and it is possible that the lower court’s decision may be reversed. However, this will not stop state courts from continuing to grant relief to deserving plaintiffs in cases of overwhelming need for the provision of physician-assisted suicide. Such cases are, after all, different only in degree from the early cases which have been thought of as establishing a right to refuse treatment. _Quinlan_, for example, is not really a right to refuse treatment case. It is a right to be killed or be assisted in suicide case. Unlike Jehovah’s Witnesses, who reject blood transfusions (despite the fact that they want very much to live) because they truly object to the blood transfusion on religious grounds, the Quinlans had nothing against the use of ventilators as a medical technique. If use of a ventilator had offered a chance of restoring Karen to a sapient, cognitive state, the Quinlans would have been glad to accept its use. The problem was that they decided that Karen would be better off dead than continuing to be maintained in a vegetative state, and they saw discontinuance of the ventilator as an appropriate and acceptable means for managing her death. Similarly in _Brophy_, there was no principled objection to artificial nutrition and hydration as such. The decision in that case was not that Mr. Brophy would under no circumstances have accepted artificial nutrition and hydration, it was that Mr. Brophy would have preferred death over continued maintenance in a persistent vegetative state, and removing food and water seemed the easy way to achieve that.

George Annas, who is himself a foe of legalization of physician-assisted suicide, has, perhaps unbeknownst, provided us with one scenario by means of which courts could legalize physician-assisted suicide through further development of common law. In 1994, Professor Annas suggested that there was no need for legislation legalizing physician assistance in suicide by lethal prescription because, if looked at in the appropriate light, such assistance in suicide is already legal. “Physicians legally can, and as a matter of good medical practice should,” says Annas, “supply prescriptions

146. _McIver_, <http://www.law.stetson.edu/mciver.htm>, at 8.
for potentially lethal drugs that have a legitimate medical use to their terminally ill patients on request, if they believe that having these drugs is likely to permit the patient to live better.  

147 Since prescribing a lethal dose of drugs for the patient who wishes to have it at the bedside for use at such time that he or she may decide to commit suicide makes the patient "feel more secure . . . and therefore . . . able to live better," 148 the doctor who prescribes such drugs commits no crime of aiding suicide. The physician's intent is not to help the patient kill him or herself, it is just to make the patient live better.

Annas's line of reasoning is one that I can easily envision being adopted into the common law of the right to die by a state court confronted by the appropriate compelling case. I also predict that such principles, and others like them, will be adopted by our courts of common law for the purpose of continuing the process of legalizing physician-assisted suicide. So long as our state legislatures continue to ignore the plight of patients who suffer and professionals who place themselves needlessly at risk, we will continue to have to rely upon our courts of common law to provide the necessary relief.

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148. Id. at 1242.