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World Court of Human Rights

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Euthanasia: Due Process for Death With Dignity; The Living Will

LUIS KUTNER*

Euthanasia, or mercy killing, has become a subject of increasing interest of late—and while no longer of mere theoretical concern, it is no less a controversial topic.¹ Indeed, the word “euthanasia” has such an emotional impact itself that a new word, “benemortasia,” has been coined for use in its stead.² Perhaps an even better term here is “death with dignity,” which means ceasing to use extraordinary or heroic means to prolong the life of a dying person.³

“Euthanasia” is derived from two Greek words which essentially translate into “easy death.”⁴ *Eu*, the first component part, means easy or painless, while the other word, *thanatos*, means death.⁵ There are two broad types of euthanasia: active euthanasia is the actual rendering of a life-shortening agent;⁶ passive euthanasia is when certain measures that might postpone death are not taken, though neither is anything done to hasten death. In the latter case, as Dr. D. B. Hiscoe of Michigan State University sees it, “[W]e are not really deciding who will die—everyone dies. We are really deciding who will be made to live.”⁷

The act of euthanasia involves either a person taking his own life in order to relieve his suffering or an outside person who takes the life of another for the same reason.⁸ Thus, euthanasia is usually considered in connection with a patient who is irrevocably unconscious or a terminal patient who himself might request some sort of action to shorten his life.⁹ Resolving the life-death decision in favor of death can be made by the individual himself¹⁰ or by another individual who, in the context of this paper observes a person suffering in pain from an incurable disease or, perhaps, a genetic deformity, and is hence motivated—not by malice or personal profit, but out of a very human desire of compassion—to end that

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¹Whittingham, *Debating Death with Dignity*, Chicago Tribune, September 27, 1974, at 10, col. 6 [hereinafter cited as Whittingham].

²Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1632 (1974) [hereinafter cited as *Informed Consent*].

³Whittingham, *supra* note 1.

⁴*Id.*

⁵Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L. J. 539, 540 n.3 (1969) [hereinafter cited as Kutner].

⁶*Informed Consent*, *supra* note 2, at 1632 n.5.

⁷Snider, *Why Patient's Death Wish Isn't Heeded*, Chicago Daily News, Sept. 23, 1973.

⁸Whittingham, *supra* note 1.

⁹*Informed Consent*, at 1632.

¹⁰Marcus, *The Forum of Conscience: Applying Standards Under Free Exercise Clause*, 1973 DUKE L.J. 1217, 1254 [hereinafter cited as Marcus].

suffering.¹¹ Beside the pain and suffering of a terminally-ill patient, among other considerations here may be the possible exhaustion of his family's financial resources in providing health care that would merely delay death through the use of expensive mechanical devices, contrary to the will of both patient and family.¹² (In speaking of a terminally-ill patient, reference is made to a person facing imminent death; beyond such a general definition medical science itself has been unable to go, given the problem of lucid intervals and remissions which the patient might go through in turn.¹³)

Euthanasia raises a myriad of philosophical, medical, legal and theological questions,¹⁴ although this debate has gone on for centuries without any resolution.¹⁵ The wish of a terminally-ill patient to forego further medical treatment in order to prolong his life may conflict with the interest and commitment of those who provide health care, as well as with existing state laws against suicide and homicide.¹⁶ But can this be called murder? It is one question that invariably arises in connection with euthanasia.¹⁷ Another is: "Why make an exception permitting death?" Instead, perhaps a better question to ask is "What exceptions should be made?"¹⁸

Such questions suggest problems which could be created if euthanasia were sanctioned. For example, since insurance companies do not pay life insurance in the case of a suicide, would not euthanasia then become a "luxury" for the wealthy? And what of a dying assault victim: if he were put to death, would his attacker then be charged merely with assault or with murder?¹⁹ Evidently, voluntary euthanasia seems too direct for most of society, which, according to Ely, would prefer an "indirect" taking of life as opposed to the shattering illusion of a direct one—with as much adverse psychological impact on people here as the refusal of treatment itself.²⁰ Some see proposals for voluntary euthanasia as opening the door for mass genocide because they think it incapable of providing the necessary safeguards.²¹

So euthanasia remains a moral-legal tangle in need of unravelling.²² This paper shall endeavor to do that.

¹¹Kutner; *supra* note 5, at 539-40.

¹²*Informed Consent*, at 1632.

¹³*Id.*

¹⁴Kutner, *supra* note 5, at 540.

¹⁵Marcus, *supra* note 10, at 1254.

¹⁶*Informed Consent*, *supra* note 2, at 1632, 1635.

¹⁷Kutner, *supra* note 5, at 539.

¹⁸*Informed Consent*, *supra* note 2, at 1648.

¹⁹Whittingham, *supra* note 1.

²⁰*Informed Consent*, *supra* note 2, at 1647, 1669.

²¹Kutner, *supra* note 5, at 549.

²²Whittingham, *supra* note 1.

Some Case Studies

That a person can lose his will to live is illustrated by the true story of a marine who had been in a Viet Cong prison camp for two years. Major F. Harold Kushner, a physician who himself spent five-and-a-half years as a prisoner of war, related how this marine had, at first, maintained his physical and mental health on assurances from the Viet Cong that he would be released in time. But, when he finally learned he was not to be released after all, he soon grew depressed, refused to eat, and just lay on his bed in a stupor. His fellow POWs were unable to bring him around and, shortly thereafter, he died. This is but one case of a person who had simply given up all hope that had previously sustained him.²³

More appropos to the subject matter of this paper is the case of columnist Bob Considine's younger brother who was suffering from the effects of inoperable cancer of the pancreas. Out of brotherly devotion, Considine took him to New York and registered him in Memorial Hospital, where he was given pills, drugs, radiation treatment and placed in an oxygen tent. Finally, Considine's brother said, "I know I'm dying. Tell...those doctors to stop doing all these painful things to me. Tell...them to let me die in peace."²⁴

The late Stewart Alsop, himself suffering from leukemia, wrote of his hospital room-mate, another terminal cancer patient, who would pitifully cry out in pain all through the night. Alsop allowed that if the fellow were a dog he would be chloroformed. "No human being with a spark of pity could let a living thing suffer so, to no good end," concluded Alsop.

[A] human being's life is his own, to keep or to leave.... [A] man of sound mind has every right to decide that the time has come for his life to end.... I am...suggest[ing] that a terminal patient in full command of his faculties should be permitted to ask a committee of experienced doctors about his future, and if he is told that it holds nothing but suffering, and death at the end, he should have the right to demand, and to receive, a pill or some other painless means of ending his life. But the right to end his own life should be his, not a doctor.²⁵

Take, further, the example of an elderly woman, hellishly lingering in her terminal illness for days or even weeks in a hospital room where she is surrounded by tubes, bottles and other assorted apparatus meant to treat her—but which has weakened her as much as the disease from which she suffers; the combined torture of pain and drugs has so confused her mind that she cannot recognize her own family; if she can think at all, perhaps her thoughts are simply of being relieved from her

²³*Submissive Death: Giving up on Life*, PSYCHOLOGY TODAY, May 1974, at 80.

²⁴Considine, *The Right to Die With Dignity*, IRISH ECHO, Aug. 3, 1974, at 13.

²⁵See, Alsop, *The Right to Die With Dignity*, GOOD HOUSEKEEPING, Aug. 1974.

suffering.²⁶ Or, what of the Jehovah's Witness who voluntarily enters a hospital for treatment? When advised that unless she is given a blood transfusion she will die, the Witness tells her doctor she cannot consent to that because of her deeply-held religious beliefs.²⁷

There is also the case of Robert Waskin, a young college student, who, on the pleading of his cancer-stricken mother, shot her three times as she lay in her hospital room. Previously, he had tried to administer sleeping pills to her. The Grand Jury of Cook County, Illinois, returned an indictment of murder in the first degree against him, but after a trial of one week, Waskin was freed by a jury, having deliberated only forty minutes, on the determination that he was temporarily insane when he committed the act. "He knew he shot his mother. That was not disputed," said the jury foreman, "but prosecution failed to show he was of sound mind when he did it." But Waskin himself had a very different response to the verdict. "The moral issue of euthanasia...was not taken up...," he said after the trial. "[I]t should have been faced squarely. Some day it will have to be."²⁸ That is the primary purpose of this paper.

LEGAL PROBLEMS

Suicide & Homicide Laws

Related to euthanasia is the law on suicide, which under early common law, was regarded as a criminal offense. Suicide was a felony, to be punished by driving a stake through the body of the one who had committed suicide and then burying the corpse under a public highway; in addition, all lands, goods and chattel of the suicide victim were forfeited to the king. This rule in England was tempered in 1824 to allow such bodies to be buried in a churchyard—yet only between the hours of 9 o'clock p.m. and midnight, and *without* religious ceremonies. Gradually, sanctions against both body and property were removed as legal attitudes toward suicide began to mellow, though an attempt by a person to end his life is still considered an attempt to commit a felony in England, albeit not an attempt to commit murder within the offenses against the Person Act of 1861. Further, while suicide is no longer a crime under English law, the aiding and abetting of suicide is.²⁹

English common law on suicide was never fully accepted in the United States, and while once a crime, suicide is no longer such in some jurisdictions, such as California. In Michigan, suicide is neither a statutory nor common law crime. New York state has declared that suicide is not a crime, but it nonetheless censured by statute as a great "public wrong"

²⁶Whittingham, *supra* note 1.

²⁷Marcus, *supra* n. 10, at 1251.

²⁸Kutner, *supra* note 5, at 539.

²⁹*Id.* at 543; *Informed Consent*, *supra* note 2, at 1659-60, 1662.

and promoting the attempt is a felony under penal law: the distinction between accessory and principal have been abolished, and those so involved are treated as principals in a homicide.³⁰

So, assistance in euthanasia could amount to the crime of aiding and abetting suicide.³¹ While some jurisdictions appear to distinguish situations where one has instigated or suggested to another that he commit suicide from those situations where the idea came originally, the law, as a rule, does not permit one to assist another in committing suicide regardless of motive or if done at the request of the suicide victim. Any immunity from suicide today actually means immunity of attempted suicide, with the law varying in different jurisdictions as to aiders and abettors. Where punishment of accessories is predicated on the criminal character of the act of the principal, the aider or abettor enjoys immunity—the act of the principal not being a crime, as prevailing in Germany and France. Other statutes specifically define aiding and abetting as an independent crime.³²

Texas was possibly the only state that viewed aiding suicide as non-criminal, absent statute. Prior to 1974, anyone who aided or abetted suicide was innocent of any violation of law inasmuch as suicide was not a crime under state law. However, now aiding or attempting to aid a suicide has become a statutory crime in Texas. Still, other states, absent statute, are not precluded from adopting the old Texas common law view on aiding and abetting suicide; and in Switzerland, a doctor is permitted to put poison in a patient's hand but not to actually administer said poison himself, thus the final act is performed solely by the patient and the involvement of the third party is minimized—somewhat similar to the Texas view before 1974.³³

Suicide itself remains a crime in yet a few jurisdictions, as in North Carolina, where it is regarded as a misdemeanor; or, in South Carolina, where suicide retains its common law character as a felony. The argument advanced for such prohibitions against suicide are usually that every life has a value to society—and if a life is taken the cost would be too great in terms of psychological damage to that society, not to mention the loss of productive potential; moreover, it is argued that one cannot take his life without self-destruction. These decisions on self-destruction may not be firmly held and may merely be pleas for help. That is certainly the case of certain classes of people—though many take their own lives out of a strong determination to do so, for reasons of physical or social calamity, or the loss of a loved one. A study of suicides among the elderly found just that, and they were neither insane nor mentally abnormal.³⁴

³⁰Kutner, *supra* note 1, at 543; *Informed Consent*, *supra* note 2, at 1660.

³¹*Informed Consent*, *supra* note 2, at 1660.

³²Kutner, *supra* note 5, at 543-44.

³³*Informed Consent*, *supra* note 2, at 1661.

³⁴*Id.* at 1660-2.

Generally, the law does not appear to condone suicide, but the law has proven to be adaptive to some situations where assistance to commit suicide is given to one who freely requests it.³⁵ It would seem that sanctions against suicide would be less defensible when particularly applied to a dying patient seeking some form of euthanasia.³⁶ Nevertheless, the law treats mercy killing no different from other cases involving the taking of human life, at least conceptually. Common law does not recognize motive as an element of homicide. If the proven facts establish that a defendant did, in fact, kill wilfully (that is, had the intent to kill, as a result of premeditation and deliberation), then there is murder in the first degree regardless of motive; relevant evidence is needed only to establish the degree of murder or homicide (premeditated).³⁷ If another assists a person to end his life, he is liable by this assistance to prosecution for murder even though the victim requested it, since consent is not defense to homicide—except in some sports contests.³⁸ Even so, prosecutors, judges, and juries have approached mercy killing cases differently, thus making an exception to the rule of law existing as far as practice is concerned. This has also served to create a gap within the legal system with regard to euthanasia, and this absence of any governing standards in this area certainly leaves much to be desired. The state of law on euthanasia, such as it is, really lacks any definitiveness or objective criteria.³⁹

Tracing Case Law

Sans symmetry of case law on euthanasia, it is perhaps best to review chronologically how the courts have handled individual cases which have had a legal bearing on this subject.

One of the earliest cases⁴⁰ held that if elements of wilful premeditation exist, the perpetrator of the act stands equally condemned regardless of the fact that he might have acted from an impulse of mercy. It is a precept that had been reaffirmed since the time of this early nineteenth century case in the United States, as well as in England.⁴¹

An important doctrine emerged out of medical malpractice suits and the courts began to deal with the rendering of some treatment to which a patient had not consented.⁴² From such cases came the doctrine of informed consent, and the landmark case in the area was *Schloendorff v.*

³⁵Kutner, *supra* note 5, at 544.

³⁶*Informed Consent*, *supra* note 2, at 1662.

³⁷Kutner, *supra* note 5, at 542, 540.

³⁸*Informed Consent*, *supra* note 2, at 1650.

³⁹Kutner, *supra* note 5, at 542-43.

⁴⁰*People v. Kirby*, 2 Park Crim. Rep. (N.Y.) 28 (1823).

⁴¹*State v. Ehlers*, 98 N.J.L. 326, 119 A. 15 (1922); *Rex v. Simpson*, 84 L.J.R. (n.s.) 1893 (K.B. 1915).

⁴²*Pratt v. Davies*, 118 Ill. App. 161, 166, *aff'd* 224 Ill. 300, 79 N.E. 562 (1906).

Society of New York Hospital.⁴³ It was in that case that Judge Cardozo opined that the principle of informed consent was meant to protect the self-determination of individuals of sound mind,⁴⁴ the basic premise being that every adult of sound mind had the right to determine what should be done with his own body. Hence, it followed that if a competent patient retains control over any decision about treatment, this right to consent presupposes the right to refuse as well; for a patient's right to informed consent would make no sense unless there was a right to an informed refusal. Every man has the right, then, to forego treatment or even a cure if it involves what, to *him*, seem intolerable consequences or risks, no matter how distorted such values may be viewed by the medical profession, just as long as the law itself does not regard them as incompetent. The implication is that there exist categories of decisions that an individual must be permitted to make, even if the individual decides irrationally or incorrectly. Basically, it is thus for the competent patient, who has the right to define what his *best* interests are under the self-determination principle of informed consent, to be able to withdraw his consent at any time and discontinue treatment.⁴⁵

The underpinnings of the informed consent axiom of self-determination over one's body, according to *Schloendorff*, might be further explained in terms more commonly applied in the law of torts from the standpoint that tort law seeks to achieve an efficient allocation of resources. While it also seeks other goals, general tort doctrine is concerned with placing the responsibility for a particular decision on those individuals who can best avoid whatever costs arise from such decision-making. The cost of avoidance here includes those attempts to reduce the number and severity of incorrect decisions, as well as the costs of gathering and considering information that go into making the decisions. It is in terms of cost avoidance that decision-making for purposes of informed consent might be evaluated, to wit: medically, a doctor, who is considered to be an expert in diagnosis and treatment, can better determine than can a patient—and at less expense—the desirability of a particular treatment; yet, the doctor is *not* equipped to evaluate treatment in terms of a patient's non-medical needs—psychological, social, and business—and, moreover, the cost to the physician in discovering all these obligations would be far too great. So, only the patient can sufficiently know his own value preference, his own capacity for pain and suffering, his religious beliefs and his uncompleted business and social plans for the future in order to evaluate the desirability and maximum satisfaction of deciding on a particular treatment. And, by alone knowing what is best for him as an individual, he becomes the optimal cost avoider.⁴⁶

⁴³*Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).

⁴⁴*Id.* at 129, 105 N.E. at 93.

⁴⁵*Informed Consent*, *supra* note 2, at 1634, 1643, 1648-49, 1664.

⁴⁶*Id.* at 1643, 1645-6, 1648.

Still, this issue of informed consent (which involves the right to a natural death) has remained unsettled—although it has always received considerable attention from the courts and commentators, many of the latter viewing the doctrine as not really central to euthanasia. Courts have applied the doctrine regularly in non-terminal cases and even in some cases of terminal illness. The concern has been with voluntary euthanasia, rather than with the involuntary euthanasia in a case of brain death—although even that has been accepted by some courts.⁴⁷

In the meantime, however, the decision in the *People v. Roberts*⁴⁸ case rendered at the beginning of the decade of the 1920s was of special import to the matter of mercy killing. The defendant in this case was a husband who had prepared poison and made it available to his wife, upon her request, by placing it within her reach. The dying wife, confined in bed with arteriosclerosis, drank the poison. The husband was found guilty of murder in the first degree by the judge because he had assisted his wife, who wished to die, by providing a means for her to commit suicide. Such assistance was held to be murder and the man was sentenced to life imprisonment.

This particular case is noted because it was one of few where a mercy killer has been convicted for murder. Perhaps this was due to the fact that the case was *not* a jury trial, for juries have often disregarded the dictates of the law and superimposed their own beliefs in mercy killing cases, as evidenced by the case of Robert Waskin, previously mentioned here. Thus, what takes place at the trial level on mercy killing cases indicates that the law in theory is actually quite malleable in practice. In the judicial process dealing with mercy killings, the decision is often based on what "is" rather than what "ought" to be, as there is a high incidence of failure to indict, suspended sentences, acquittals (such as finding a defendant innocent because of insanity), or a finding of guilt for a lesser offense than murder when a killer has had mercy as a motive. It would seem that, while there is opposition to mercy killing, there is, nonetheless, sympathy for the killer, that is, the defendant. Since there is usually a human interest aspect to mercy killing cases, they receive wide press coverage and public attention. Unlike other acts of murder, the public does not have the same revulsion toward mercy killings. The tendency is to side with the defendant and not to favor the same type of punishment society inflicts on other murders. During the Waskin trial, for example, the judge, the defendant's father and lawyer all received letters urging mercy be shown. And over forty years after *Roberts*, the case of Suzanne van de Put, a Belgian woman who had killed her eight-day-old, thalidomide-deformed daughter, gained international attention. Mrs. van de Put went on trial in Liege for murder, along with her husband, mother, sister and family doctor who were arraigned as abettors. The

⁴⁷*Id.* at 1645, 1634.

⁴⁸*People v. Roberts*, 211 Mich. 187, 178 N.W. 690 (1920).

defendants claimed to have acted from what they felt were unselfish motives and popular sympathy was with them. The trial lasted only six days, with the jury finally acquitting all five defendants—a verdict that was met with general exultation.⁴⁹

Throughout the 1930s and 1940s, U.S. courts considered a number of relevant cases involving suicide;⁵⁰ but also during the latter decade there was decided a case in the area of competency to consent, whereby it was held that, while informed consent need not be obtained from an incompetent patient, it must be obtained from said patient's guardian.⁵¹ Later, in the *In re Serferth* case,⁵² decided in the following decade, there was no guardian, however.

The year 1958 brought several important decisions from various jurisdictions. One case⁵³ illustrates how one trial court approached mercy killing. The sixty-nine year-old defendant had suffocated his wife, a hopeless cripple bedridden by arthritis. In arraignment proceedings, the state waived the murder charge and permitted the defendant to enter a guilty plea to the charge of manslaughter. The court then found the defendant guilty of this charge on his stipulated admission of killing. After hearing testimony of the defendant's children and pastor concerning his unflinching care for and devotion to his wife's two-year illness, and reading a letter from the deceased's doctor attesting to her excruciating pain and mental despair, the court allowed the defendant to withdraw his plea and entertained a plea of "not guilty," then so found him not guilty because under the circumstances the jury "would not be inclined to convict." Because there was no reason to be concerned about recidivism, the court withheld the "stigma" of a finding and judgement of guilty by allowing the defendant "to go home...and live out the rest of [his] life in as much as [he] can find it in [his] heart to have." In following such a procedure in this case, the court was acting out of a sense of justice; the decision was based on the motives of the defendant—although this was unauthorized by statute. While the court had discretion to permit a defendant to withdraw a guilty plea, that discretion was limited to those particular instances where it would appear that there is doubt as to a defendant's guilt, or that he has any defense at all worthy of consideration by a jury, or, further, that the ends of justice will be served by submitting the case to a jury. However, these criteria were absent in this particular case.⁵⁴

⁴⁹Kutner *supra* note 5, at 540-42.

⁵⁰See, *Stiles v. Clifton Springs Sanitarium Co.*, 74 F. Supp. 907, 909 (W.D.N.Y. 1947); *State v. Campbell*, 217 Iowa 848, 850, 251 N.W. 717, 718 (1933); *Huntert v. Commercial Travelers' Mut. Accident Ass'n. of America*, 244 App. Div. 459, 460, 279 N.Y.S. 555, 556 (1935).

⁵¹*Bonner v. Moran*, 75 U.S. App. D.C. 156, 157-8, 126 F.2d 121, 122-3 (1941).

⁵²*In re Serferth*, 309 N.Y. 80, 127 N.E.2d 280 (1955).

⁵³*People v. Werner*, Crm. No. 58-3636 (Cook Co. Ct., Ill. 1958).

⁵⁴Kutner, *supra* note 5, at 541.

The number of cases dramatically increased in the 1960s and early 1970s, especially insofar as informed consent was concerned. As the decade of the 1960s began, the *Schloendorff* axiom on an individual's self-determination was restated by a Kansas court in the noted case of *Natanson v. Kline*.⁵⁵ The court, basing its opinion on the premise of thoroughgoing self-determination under Anglo-American law, held that each man must then be considered to be the master of his own body, and so may expressly prohibit the performance of surgery to save his life or any other medical treatment—provided he was of sound mind. While a doctor might feel an operation or some form of treatment was desirable or necessary, the court stated that the law would not permit him to substitute his own judgement for that of the patient by any form of artifice or deception.

Following *Natanson* during the 1960s, however, some courts refused to recognize the doctrine of informed consent⁵⁶ and enforced the overruling by doctors of patients' refusal of treatment. Such a case was that decided in 1964 (among others) where the Appellate Court of the District of Columbia "determined to act on the side of life" overruled the refusal of a blood transfusion by a Jehovah's Witness.⁵⁷ The court maintained that the woman needed the transfusion to save her life and she was not in a mental condition to make such a lifesaving decision. The decision suggested that there was authority to apply anti-suicide sanctions to individuals seeking euthanasia for religious purposes, the court having noted that when death results "from failure to extend proper medical care, where there is a duty of care" it is manslaughter in the District of Columbia.⁵⁸

Future Supreme Court Chief Justice Warren Burger, then a circuit judge, dissented because he felt a hospital's effort to compel a person to accept a blood transfusion against her will was not justifiable. "Some matters of essentially private concern and others of enormous public concern," he wrote, "are beyond the reach of private concern and others of enormous public concern are *beyond the reach of judges*." [Emphasis added]. Discussing the allocation of decision-making powers, Burger quoted Mr. Justice Brandeis on "the right to be let alone" and averred that such privacy includes refusal of medical treatment even at great risk, no matter how foolish, unreasonable or absurd that notion may seem.⁵⁹ Of course, implicit in the weighing of interests competing in decision-making is resolution by free choice.⁶⁰ Yet, one need only look at motorcycle crash helmet cases, for example, to see the difficulty in the allocation of decision-making power for choices that apparently affect on-

⁵⁵186 Kan. 393, 350 P.2d 1093, *rehearing denied*, 187 Kan. 186, 354 P.2d 670 (1960).

⁵⁶*Informed Consent*, *supra* note 2, at 1633.

⁵⁷Application of Pres. and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964).

⁵⁸*Id.* at 89 n.18.

⁵⁹*Id.* at 98.

⁶⁰*Informed Consent*, *supra* note 2, at 1643.

ly a given individual: in the same year one court found the helmet requirement invalid, since an individual was not held accountable to society, in the eyes of that court, for any actions that concern no one but himself,⁶¹ but another court held the requirement valid.⁶²

Some courts accepted the Burger pronouncement that resolving the issue of avoiding treatment is "beyond the reach of judges." In such life-and-death decisions, the "free exercise" clause of the First Amendment of our Constitution, which occupies a "preferred position" with other constitutionally protected rights, began to take on a wider scope and application in the courts—whereas before its newfound judicial flexibility, individuals asserting the clause had not been very successful in state or federal courts. Still other courts agreed with the majority opinion in the D.C. case and saw the state as having the power to protect its citizens against themselves even in the face of the "free exercise" clause.⁶³ In the same year as the above D.C. case was decided, another court held that a woman may be compelled to accept a blood transfer for her unborn child since the unborn child is entitled to the law's protection.⁶⁴ Also in the following year, a court again took the position of protecting a citizen's life even though this protection was against the individual's wishes.⁶⁵

Nevertheless, no proper legal outcome to the question was settled upon during that decade—and especially in one jurisdiction, New York, the lower courts were most inconsistent. After *Natanson* but before the D.C. case previously cited, a New York court followed the patient's wishes in the interest of self-determination, ruling that a terminal patient, just as one who is non-terminal, is entitled to refuse treatment.⁶⁶ It extended the right to refuse to the dying patient, giving him a choice on proffered treatment like in any other medical situation. An Illinois case adopted a similar approach three years later: the State Supreme Court upheld the refusal of a blood transfusion by a Jehovah's Witness, a competent adult who had steadfastly asserted her religious belief against such a transfusion—despite the fact she was *in extremis*. The court noted that there were no minors involved and no clear and present danger to society.⁶⁷ However, in New York the same year as the D.C. case (1964 was evidently a banner year for cases of this sort), a court compelled treatment.⁶⁸ Two years thereafter, though, a New York judge refused to intervene in the dispute or treatment of an eighty year-old person suffering

⁶¹American Motorcycle Association v. State Police, 11 Mich. App. 351, 158 N.W.2d 72, 73-4 (1968).

⁶²State ex. rel. Colvin v. Lombardi, 104 R.I. 28, 241 A.2d 625 (1968), *aff'd*. State v. Lombardi, 110 R.I. 776, 298 A.2d 141 (1972).

⁶³Marcus, *supra* note 10, at 1218, 1220, 1254, 1271.

⁶⁴Raleigh Fitkin - Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 423, 201 A.2d 537, 538, *cert. denied* 377 U.S. 985 (1964).

⁶⁵United States v. George, 239 F. Supp. 752 (D. Conn. 1965).

⁶⁶Erickson v. Dilgard, 94 Misc.2d 27, 252 N.Y.S.2d 705 (S. Ct. 1962).

⁶⁷In re Brooks' Estate, 32 Ill.2d 361, 205 N.E.2d 435 (1965).

⁶⁸Collins v. Davis, 44 Misc.2d 622, 2524 N.Y.S.2d 624 (S. Ct. 1966).

from gangrene; thus, the patient's apparent refusal of an operation prevailed.⁶⁹

Those courts that purported to apply the *Schloendorff* principle (as restated in 1960 by *Natanson*) actually developed a wide variety of formulations that served to inhibit realization of ultimate patient control. Courts overlooked the patient's self-determination by either focusing on the therapeutic privilege to withhold information or by basing its determination of the physician's liability on the disclosure standards of the local medical community.⁷⁰ Such judicial deviations appeared in a mix of cases throughout the 1960s. Early in the decade one jurisdiction held that the duty of disclosure was based on community standards requiring only the disclosure of risks consistent with the practice of the local medical community.⁷¹ That ruling was in common with most other jurisdictions in the United States.⁷² But within a year one court had abolished medical community standards and adopted in their place new disclosure standards, while utilizing the reasonable man standard to retain some limits on physicians liability.⁷³ Also that year, another court found liability for psychic injury—but only if disclosure was grossly negligent, capricious, not well-founded and inducing harmful therapy.⁷⁴ Further, in connection with *Natanson*, "any conflict between [the doctor's primary duty to do what is best for the patient] and that of frightening disclosure," opined a court four years after, "ordinarily should be resolved in favor of the primary duty."⁷⁵ And, as some courts began adopting a negligence theory for informed consent in the mid-1960s, it too differed greatly from jurisdiction to jurisdiction as to what constituted risk.⁷⁶

Through-out the decade of the 1960s a few cases stand-out because of their relation to the subject of euthanasia, running from a case in which assistance in a suicide was found to be manslaughter⁷⁷ to a later case in which the court said that "protection of the safety of all...against consequences of their own actions" was a legitimate use of a state's police powers.⁷⁸ Also worthy of note here is the dictum in the *People v. Conley* case, where the strong indication was given that complicity in active euthanasia even by a well-intentioned physician would constitute sufficient malice for a murder prosecution. "[O]ne who commits euthanasia bears no ill will toward his victims and believes his act is morally

⁶⁹Petition of Nemser, 51 Misc.2d 616, 273 N.Y.S.2d 624 (S. Ct. 1966).

⁷⁰*Informed Consent*, *supra* note 2, at 1633.

⁷¹*DiFilippo v. Preston*, 53 Del. 539, 550, 173 A.2d 333, 339 (1961).

⁷²*Informed Consent*, *supra* note 2, at 1637.

⁷³*Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962).

⁷⁴*Draus v. Speilberg*, 37 Misc.2d 519, 236 N.Y.S.2d 143 (S. Ct. 1962).

⁷⁵*Watson v. Clutts*, 262 N.C. 153, 159, 136 S.E.2d 617, 621 (1964).

⁷⁶*Informed Consent*, *supra* note 2, at 1633.

⁷⁷*Persampieri v. Commonwealth*, 343 Mass. 19, 175 N.E.2d 387 (1961).

⁷⁸*Bisonius v. Karns*, 42 Wis.2d 42, 52, 165 N.W.2d 377, 382, *appeal dismissed* 395 U.S. 709 (1969).

justified," said the court, "but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief."⁷⁹

Although the present decade has not yet ended, the volume of cases already decided in this area is quite large, indeed.

A number of cases decided during 1971 took in the wider issue of constitutional rights along with that of informed consent. This was initiated by the *John F. Kennedy Memorial Hospital v. Heston*,⁸⁰ where the court ordered a blood transfusion in the interest of protecting a citizen's life, thereby compelling a twenty-two year-old Jehovah's Witness to receive the life-sustaining transfusion over her objections. The patient was paid to have submitted to the doctor's "professional standard" by requesting treatment and the doctor was to treat accordingly, not to terminate such treatment before death.⁸¹ But in another 1971 case, involving a Christian Scientist, the court reversed the prior holding of a lower New York state court, which in league with a health care provider, had forced a patient, involuntarily committed to a hospital for treatment of an alleged mental illness, to take tranquilizers over her religious objections. In its reversal, the court found there was a cause of action under the 100 year-old Civil Rights Act of 1871.⁸² Thus, the court drew a connection between the constitutional doctrine of freedom of religion and the doctrine of informed consent, with the former seeming to be a foundation for the latter. The majority of the court had also based its decision on the distinction between instances of harm to others and to self, which was "rarely if ever...relevant in actuality because others are affected by virtually any action...an individual takes or fails to take," according to the dissent of one judge.⁸³

Further, in 1972, it was held in *In re Osborne*, again involving a Jehovah's Witness, that a competent and informed adult patient was entitled to refuse treatment on religious grounds over and against state intervention—even if that treatment were to save the patient's life. The court distinguished earlier cases involving compulsory rendition of medical care to which patients objected on religious grounds, noting that some cases involved comatose patients or other incompetents while, in other cases, lives of unborn or the welfare of survivors were at stake.⁸⁴ It particularly distinguished *Heston* as protecting the lives of unborn children.⁸⁵ (That distinction may have later been weakened by *Roe v. Wade*,⁸⁶ which legalized certain abortions as within the zone of constitutionally protected privileges. But even before *Roe*, in the same year as

⁷⁹People v. Conley, 64 Cal.2d 310, 322, 411 P.2d 911, 918, 49 Cal. Rptr. 815, 822 (1966).

⁸⁰John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971).

⁸¹*Id.* at 583, 279 A.2d at 673.

⁸²Winters v. Miller, 496 F.2d 65 (2d Cir.), cert. denied 404 U.S. 985 (1971).

⁸³*Id.*

⁸⁴In re Osborne, 294 A.2d 372, 374-75 (D.C. App. 1972).

⁸⁵*Id.* at 374.

⁸⁶401 U.S. 113 (1973).

Osborne, a court had suggested in a New Jersey case striking down a state abortion statute as unconstitutional that there was no authority for a state to infringe on constitutional rights for the purposes of general welfare.⁸⁷ Still, it should be noted that the Supreme Court in *Roe* did not say that there was any right to do with one's body as one pleased.⁸⁸ *Osborne* stressed that whether the patient's "current choice is competently maintained" is to be the important thing.⁸⁹

In a final 1972 case, *In re Green*, involving a family of Jehovah's Witnesses, the state of Pennsylvania brought an action to have a guardian appointed for a 14-year-old patient whose parents would not allow him to have a blood transfusion for a spinal fusion operation. The court failed to find any showing that the child's life was in imminent danger and upheld the free exercise interest of the patient (which interest had been expanded in the Supreme Court culminating in a case decided during this same year).⁹¹ However, the court in *Green* remanded the case to determine if the child agreed with his parent's decision concerning the blood transfusion.⁹² Courts have appointed requested guardians if the patient was a minor or mentally incompetent, but there is also conflict whenever an individual is capable of making rational choices.⁹³

As commentators Harper and James have declared, "Individual freedom... is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones. Thus, the Jehovah's Witness should have the legal right to refuse—on religious grounds which seem mistaken to most of us—the blood transfusion which is needed to save his life...."⁹⁴

A trial of cases from 1972—*Cobbs*,⁹⁵ *Wilkinson*,⁹⁶ and *Canterbury*⁹⁷ abolished medical community standards on disclosure and formed new tests for disclosure by each taking different approaches toward that issue.

In *Cobbs* the court opted for a standard more protective of the patient's rights, requiring disclosure of known risks of death or serious bodily harm. The court was viewing insufficient disclosure of risks and alternatives as a failure to exercise due care, the failure of obtaining informed consent being a tort of negligence.

In speaking of the patient's need for information, the court says the test for adequate disclosure encompasses "whatever is material to the

⁸⁷*Y.W.C.A. v. Kugler*, 342 F. Supp. 1048, 1073 (D.N.J. 1972).

⁸⁸*Roe v. Wade*, 410 U.S. 113 (1973).

⁸⁹*In re Osborne*, 294 A.2d at 375.

⁹⁰*In re Greene*, 448 Pa. 338, 292 A.2d (1972).

⁹¹*Wisconsin v. Yoder*, 406 U.S. 205 (1974).

⁹²*In re Greene*, *supra* note 90.

⁹³*Marcus*, *supra* note 10, at 1252.

⁹⁴Quoted in *Informed Consent*, *supra* note 2, at 1748.

⁹⁵*Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

⁹⁶*Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972).

⁹⁷*Canterbury v. Spence*, 464 F.2d 722(D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

decision."⁹⁸ But that standard is left undefined and no clear test is arrived at as to whether the court is talking about an objective test (based on the so-called "reasonable man") or subjective test (based on the individual patient).

Moreover, *Cobbs* allowed a waiver of the right to disclosure by a competent patient; and if he expresses that wish the doctor is then advised to exercise therapeutic privilege in withholding information from him.⁹⁹

The Rhode Island Supreme Court in *Wilkinson* decided that a patient must be given all necessary material information, the charter of which could not be determined by "a local medical group" having no knowledge of the individual or unique situations involved. It was further noted that informed consent is based on the right of the patient "to be the final judge to do with his body as he wills"—a right that "should not be delegated to a local medical group." *Wilkinson* employed a reasonable man test—the objective standard—with regard to the withholding of information.¹⁰⁰ The test was "isolated" and "concentrated" to apply only to determining the required scope of disclosure.¹⁰¹ The doctor was held responsible only for disclosing all facts and risks a reasonable man would deem material.

The court in *Wilkinson* recognized that a physician might feel a patient would be "upset" by information and so withhold relevant facts on the familiar grounds of therapeutic privilege. From that, it concluded that no disclosure was necessary if "it would unduly agitate or undermine an unstable patient."¹⁰²

The situation in the *Canterbury* case is similar to that of *Wilkinson* in that the treatment performed was not consented to. The court in *Canterbury* said that informed consent requires a competent, non-terminal patient in a non-emergency situation to be given a chance to consent or refuse. The court stressed the competency of the patient out of recognition of the importance of comprehending the information conveyed. Because the patient lacks the expertise of a doctor, he must rely heavily on the doctor for information about the nature and quality of the treatment.¹⁰³

On a patient's refusal, the court in *Canterbury* noted that an ideal rule governing disclosure should require that all risks which the patient would feel material be revealed; yet, the court was aware that such a subjective rule would place an "undue demand" on a doctor to "second-guess" the patient. So the court applied *both* the reasonable man test and an objective causation test. Under this combined test, the more severe or likely the risk, the more probable the facts are material.¹⁰⁴ The focus here

⁹⁸*Cobbs v. Grant*, 8 Cal.3d 229, 245, 502 P.2d 1, 11 (1972).

⁹⁹*Id.*

¹⁰⁰*Wilkinson v. Versey*, 110 R.I. 606, 626, 295 A.2d 676, 689 (1972).

¹⁰¹*Informed Consent*, *supra* note 2, at 1642.

¹⁰²*Wilkinson v. Vesey*, 110 R.I. at 628, 295 A.2d at 689.

¹⁰³*Canterbury v. Spence*, 464 F.2d at 780-83, 790-91.

¹⁰⁴*Canterbury v. Spence*, 464 F.2d at 780-83, 790-91.

is on the magnitude of risks and the likelihood of their occurrence as perceived by the reasonable man. In so doing, the test would seem to clearly put a doctor on notice as to the necessity of disclosure.¹⁰⁵

The *Canterbury* opinion also moved in the direction of viewing the invocation of therapeutic privilege as the equivalent of asserting a patient incompetent. The court rejected likening the claim of therapeutic privilege to conceal information to that of asserting the community standard against disclosure. Instead, it cut back on therapeutic privilege. The "privilege to withhold information for therapeutic reasons must be carefully circumscribed," decided the court so that it would not "devour the disclosure rule itself." While placing only an outer limit on the privilege, the court still suggested that if the privilege were exercised there should be disclosure to the closest relative.¹⁰⁶

Another 1973 case, similar to a 1966 case from the same jurisdiction, as previously cited, resulted very differently result when a judge appointed a guardian to consent to an operation on an 84-year-old suffering from gangrene despite a dispute as to what his wishes were.¹⁰⁷ But when a sixty year-old woman suffering from cancer refused life-saving surgery, giving as a reason that she had fears over such an operation—fears other witnesses suggested were based on the belief that the surgery would prevent a movie career, a lower court in Pennsylvania held that this chronic undifferentiated schizophrenic was nevertheless sufficiently competent to refuse, although some might consider her reasons irrational. But the court allowed her to make this decision, using as its test that of the patient's capacity to comprehend the situation's risks and alternatives, *sans* any examination of whether the patient's choice is rationally or dispassionately conceived. So, in the eyes of the court, a terminal patient who had decided to die for reasons irrational to others should have that decision honored, since informed consent protects all the decisions of a competent patient.¹⁰⁸

In upholding this schizophrenic's right to refuse, the court in *Yetter*, above, recognized a connection between that right and the right of privacy, referring to *Roe v. Wade*, where the U.S. Supreme Court based its decision on the 14th Amendment right to privacy *vis-a-vis* the interests of the state.¹⁰⁹ Of course, the constitutional right to privacy had already been recognized by the Supreme Court in *Griswold v. Connecticut*.¹¹⁰ The Court in *Roe* claimed that the commitment to self-determination and privacy presupposes a disposition to permit activities whose adverse impact on others would be only psychological.¹¹¹ Said the

¹⁰⁵*Informed Consent*, *supra* note 2, at 1690.

¹⁰⁶*Canterbury v. Spence*, 464 F.2d at 789.

¹⁰⁷*Center v. Levitt*, 73 Misc.2d 395, 342 N.Y.S.2d 356 (S. Ct. 1973). See note 74, *supra*.

¹⁰⁸*In re Yetter*, Civil No. 1973-533, at 2-3, 5 (Pa. C.P. N'ampton Co., June 6, 1973).

¹⁰⁹410 U.S. 113 (1973).

¹¹⁰381 U.S. 476 (1965).

¹¹¹*Roe v. Wade*, 410 U.S. 113,152-56 (1973).

lower court in *Yetter*:

In our opinion the constitutional right of privacy includes the right of a mature competent adult to refuse to accept medical recommendations that may prolong one's life and which, to a third person at least, appear to be in his best interests, in short, that the right of privacy includes a right to die with which the state should not interfere where there are no minor or unborn children [actually departing from the sum and substance of the *Roe* ruling here] and no clear and present danger to public health, welfare or morals. If the person was competent while being presented with the decision and in making the decision which she did, the court should not interfere even though her decision might be considered unwise, foolish or ridiculous.¹¹²

It now appeared that informed consent was being viewed as a manifestation of constitutionally protected rights.¹¹³ Another case from 1973 seems to have borne this out when it was further decided that the denial of retirement benefits to an employee whose religion prohibited life-saving surgery, thus rendering her disabled, was an unconstitutional infringement on her free exercise of religion.¹¹⁴

Two of the most recent decisions rendered have further contributed to case law here. They are important, each in their own way: In *Lacy*, the court overtly ignored the individual values of the patient. The facts of the case were that a blood transfusion was recommended for an infant in Florida, but the child's parents were Jehovah's Witness and flew the boy to a Texas hospital which treated such patients without transfusions. It was alleged that the doctor in Florida notified the hospital and welfare unit in Texas that the infant was in immediate danger of death. The welfare unit then obtained a court order—*sans* notice—making the child a ward of the state. The sheriff next transferred the infant to a general hospital where the boy received a blood transfusion over the complaints of the plaintiffs.¹¹⁵ Some feared this action might lead others in similar circumstances to avoid or delay consulting a physician because their values might be disregarded, and, by neglecting to seek medical advice, risk the deterioration of health standards at the cost of society.¹¹⁶

In the second current case, it was held that the Department of Health, Education, and Welfare regulations were arbitrary and unreasonable since they did not sufficiently protect welfare clients against coercion.¹¹⁷ In the regulations in question, HUD had defined the doctrine of informed consent as "the knowing consent of an individual or his legally

¹¹²In re *Yetter*, *supra* note 108 at 4.

¹¹³*Informed Consent*, *supra* note 2, at 1644.

¹¹⁴*Montgomery v. Board of Retirement*, 33 Cal. App.3d 447, 109 Cal. Rptr. 181 (1973).

¹¹⁵*Lacy v. Harris Co. Welfare Unit*, Civil No. 74-H-129 (S.D. Tex., filed Jan. 22, 1974).

¹¹⁶*Informed Consent*, *supra* note 2, at 1646.

¹¹⁷*Relf v. Weinberger*, 392 F. Supp. 1196 (D.D.C. 1974).

authorized representative, so situated as to be able to exercise free power or choice without undue inducement or any element of force, fraud, deceit, duress and other forms of constraint or coercion...."¹¹⁸ Coerced consent could take the form of subtle pressure from others, unconscious motivation, or simply a failure to comprehend information in the form conveyed. Particularly vulnerable to the influence of family members, drugs, pain, and financial problems is the terminal patient. That poses a special problem, increasing the number and frequency of incorrect and irreversible decisions on the part of the patient. There is a greater cost to society here imposed than if the responsibility were placed on the state, for example. But, indeed, the thrust of the above decision implies that the state should do more to protect an individual from such coercion. In formulating a suitable test in order to handle the problem of coercion, it has been suggested that the state can structure its approach along those lines whereby the relatively uncoerced patient can alone make the ultimate decision as to treatment, with the state itself striving to assure that he makes it with true understanding. It may be asserted, on the other hand, that the state, if it has an interest here, should then override the expressed will of the patient.¹¹⁹ Yet, as can be seen through-out this chronological review of case law, it has been questioned from time to time as to whether the mere fact an individual wishes to resolve the decision of life or death in favor of the latter should automatically give rise to any strong state interest whatever.¹²⁰

In case law effecting euthanasia, the judicial process has treated mercy killing differently than murder with malice.¹²¹ However, few cases on the issue of liability for euthanasia ever reach the courts, due, in part, to prosecutorial discretion, or, for the larger part, difficulty of proof, or, more simply, failure of authorities to discover the act (morphine, for example, is an easily disguised death-inducing agent). Moreover, criminality of inaction by physicians has not been generally decided by the courts, especially in America.¹²² As a matter of fact only two prosecutions of doctors for murdering dying patients have been recorded in American and British law. Yet, those courts that have upheld the doctrine of informed consent in the numerous cases cited above, have, in fact, recognized the right of a competent patient to forego treatment.¹²³

Although some courts, questioning the validity of the *Schloendorff* axiom, have stressed concerns countervailing that principle, most recent cases abolishing the medical community standard rule on disclosure have returned to a position of greater consistency with *Schloendorff*.¹²⁴ So case

¹¹⁸Quoted in *Informed Consent*, *supra* note 2, at 1633.

¹¹⁹*Id.* at 1656-57.

¹²⁰Marcus, *supra* note 10, at 1254.

¹²¹Kutner, *supra* note 5, at 549.

¹²²*Id.* at 548.

¹²³*Informed Consent*, *supra* note 2, at 1662, 1664.

¹²⁴*Id.*, at 1631.

law has evidently come full-circle. Concerns over the psychological impact on society of refusing treatment has not been strong enough to overcome the law's commitment to an individual's decision-making with regard to his or her own medical treatment.¹²⁵ Such decisions must rest with the patient, and the law will recognize the right to consent to or refuse treatment—even when a patient is *in extremis*—whether it be an infection or an operation to extend life, *providing* the patient is capable of giving consent and that that consent is both voluntary and informed. This right has been further buttressed by the constitutionally recognized right to privacy. If a patient is incapable of giving his consent (he may be unconscious), constructive consent to life-saving treatment may be presumed, but how far such constructive consent should be extended is to be answered on the basis of the best available evidence according to the rule of law that merciful termination of life shall be decreed.¹²⁶

The courts must take care so there will be no accretions of the doctrine of informed consent that will diminish the patient's entitlement to receive information on risks involved and to consent before treatment. These two elements—information and consent—are, of course, essential to the doctrine, but they are not as settled in the courts as is a third element: the concept that a patient must comprehend the information conveyed, which the courts have more fully developed since the notion of informed consent itself came into being. Some courts have joined the concept of determining competency with the use of therapeutic privilege (which a doctor could abuse as a loophole through which to avoid providing information for informed consent). These courts expand therapeutic privilege into the presumption of incompetency, resulting in a possible denial of a patient's right to make his own decision on euthanasia. To safeguard patients' interests, adequate legal tests on competency should be carefully formulated by the courts instead, in order that patients will not be so manipulated. Unfortunately, courts have been lax in considering such tests. In addition to the judicial permissiveness of therapeutic privilege, courts trending in the direction of holding a doctor liable for even honest, though frightening, disclosures should re-examine such an approach, for it may impede the flow of material information to the patient. In its place, the law should concentrate on developing the duty to inform the patient fully, yet tactfully, of material information, however distressing, so that, in the interest of informed consent, he can make an informed decision.¹²⁷

Another area that has not received extensive attention (at least not on the appellate level) is the measure of damages to be recovered in an informed consent tort action, as the cases above demonstrate. For there to be cause for tort liability, it would have to be proven that damages resulted from concealment; though any requirement that the patient

¹²⁵*Id.*, at 1664.

¹²⁶Kutner, *supra* note 5, at 547, 549-50.

¹²⁷*Informed Consent*, *supra* note 2, at 1631, 1636-7, 1651-2, 1659.

show he would have been better off had he undergone alternative treatment would lead to the introduction of highly speculative considerations in many cases as to proofs for damage. It is for the courts, however, to develop a tort doctrine on informed consent—and only they can achieve it.¹²⁸

Legislative Responses

Euthanasia has also been a subject of legislative, as well as judicial, consideration.¹²⁹ Given the uncertainties of suicide and homicide laws, legislation authorizing some sort of euthanasia seems to be desirable.¹³⁰ But, for others, legislative ends are to preserve human life, and, to date, all proposals to legalize voluntary euthanasia have been rejected.¹³¹

Noted legal scholar Glanville Williams long urged enactment of a statute to permit voluntary mercy killing, which was backed by proponents of euthanasia in both the United States and England. It was originally designed to establish a means of immunizing relatives or physicians in administering means of ending life upon the request of a patient who was suffering great pain from an incurable, fatal disease.¹³² The Williams proposal would recognize the *de facto* power of the health care provider by leaving the rendition of euthanasia to the discretion of the doctor and, thus, minimizing the risk of litigation. However, by legally utilizing the doctor's discretion over the decision of euthanasia, rather than having it made by the patient himself, Williams disregarded informed consent.¹³³

The House of Lords in England defeated a bill to allow voluntary euthanasia for Britain in 1969. The opponents charged that it would allow "suicide by proxy." This is one of many arguments raised against voluntary euthanasia proposals. It is further asserted that such laws would prove too cumbersome if applied and could not provide the necessary safeguards.¹³⁴ To be sure, in order to provide the latter, the sick room would have to become overly "bureaucratized," and the period between the request for euthanasia and its actual rendition could be quite long.¹³⁵ But the greatest objection to such proposals seems to be the fear that they could open the door to possible mass euthanasia and genocide to eliminate the aged or the congenitally defective. This "entering wedge" theory finds support in the Nazi experience in Germany: euthanasia was expanded from the "voluntary" stage to the elimination of the mentally ill and defective, and finally as a rationale for genocide.

¹²⁸*Id.*, at 1641, 1644.

¹²⁹Marcus, *supra* note 10, at 1253.

¹³⁰*Informed Consent*, *supra* note 2, at 1659.

¹³¹Kutner, *supra* note 5, at 545, 549.

¹³²*Id.*, at 544-45.

¹³³*Informed Consent*, *supra* note 2, at 1650-51, 1659.

¹³⁴Kutner, *supra* note 5, at 547, 549.

¹³⁵*Informed Consent*, *supra* note 2, at 1663.

Thought was even given to eliminating all cardiac patients, as well. (Today, under the German legal system, though, the approach toward mercy killing is that there should neither be exculpation nor reduction of sentence where death is administered for the benefit of persons other than a suffering patient. The failure of a doctor to artificially prolong a painful life is not regarded as a homicide as long as the victim is incurably ill. Otherwise, there is a duty to act and intent to cause death is punishable as homicide.)¹³⁶ That legalized voluntary euthanasia might soon lead to involuntary euthanasia ignores the main difference between the two: informed consent—a greater difference than exists between active or passive euthanasia (act *vis-a-vis* omission). So, the legal definition of euthanasia could be limited to include only those terminal patients who gave their informed consent, thus preventing mercy killing of any non-consenting terminal patients.¹³⁷

Euthanasia legislation has fared little better in America than in England. Despite bills in many state legislatures relative to absolving physicians of any liability, none has yet been passed.¹³⁸ The American Euthanasia Society supported one proposal that was unsuccessfully introduced in bill form in both the Nebraska and New York legislatures. Under the proposal, an eligible patient would have petitioned for euthanasia in the presence of two witnesses. The petition would then be filed, along with a certificate from an attending physician in a court of appropriate jurisdiction. This court would next appoint a committee of three, at least two of whom would be physicians. The committee would forthwith examine the patient and other such persons as they deemed advisable or the court might direct. Within five days the committee was to report back to the court on whether or not the petition should be granted.¹³⁹

Other legislative attempts at legalizing passive euthanasia were made in Florida and Oregon. Opponents of the bill in the Florida legislature were successful in memorializing Congress to pass a constitutional amendment to prohibit both active and passive euthanasia before the passive euthanasia bill could again be re-introduced. The Oregon bill died in committee, though the state medical society was behind it; the general public, however, was not. This brought the sponsor of the bill to the realization that such a bill was not politically feasible but a "political liability" instead. Therefore, he "reluctantly" concluded not to re-introduce the bill and to "depend on social education" to change public opinion before going the legislative route again. And although a Patient's Bill of Rights was enacted in Minnesota, it did not include the right to

¹³⁶Kutner, *supra* note 5, at 545-6, 548.

¹³⁷*Informed Consent*, *supra* note 2, at 1663.

¹³⁸Reinhold, *Facing the Last Taboo: Death*, Chicago Tribune, July 28, 1974, Sec. 2, at 1 [hereinafter cited as Rheingold].

¹³⁹Kutner, *supra* note 5, at 544-45.

refuse treatment.¹⁴⁰

Still, lawmakers need to generate adequate legal measures that will permit death with dignity, and, to that end, legislation should dispel any fear of possible criminal liability in cases of voluntary euthanasia. Legislation reducing fear of liability for complicity in certain forms of voluntary euthanasia would allow the patient's wishes to be honored, for, with liability removed, more deference to the patient's wishes would surely be expected.¹⁴¹ Criminal codes can be adapted to meet the situation. One suggestion is to return to motive (rather than intent) in criminal law here as other legal systems have done. For example, under modern European codes motive is considered relevant in classifying offenses. There could then be a milder punishment than in other homicides for an accused who had killed at the request of the victim suffering in great pain from an incurable disease. So, if the renderer of euthanasia has good motive he will be punished—if punished at all—for a lesser offense than murder.¹⁴² Further, the prohibition of suicide could be limited to non-terminal cases by changing the definition of suicide to clearly exclude voluntary passive euthanasia.¹⁴³

ETHICS & EUTHANASIA

Medical & Theological Ethics

Doctors feel they have a duty to act in the best interest of their patients, as they perceive that duty, according to professional standards based on the theory of medicine under which they are trained.¹⁴⁴ Medicine is seen as the implacable foe of death,¹⁴⁵ and, given the advancements in medical technology,¹⁴⁶ it is possible today for medical science to prolong life artificially through mechanical methods to keep such vital functions as circulation and respiration going;¹⁴⁷ moreover, operations to transplant human organs, like a heart or kidney, have now become routine due to these advances: they give patients a second chance at life.¹⁴⁸ But in other cases, it is not human life that is prolonged but merely vegetation.¹⁴⁹ Still, as one doctor admits about many of his colleagues, they "have a dread of death so great they can scarcely function in its

¹⁴⁰*Informed Consent*, *supra* note 2, at 1634.

¹⁴¹*Id.* at 1659, 1663-64.

¹⁴²*Id.* at 1651; Kutner, *supra* note 5, at 546, 549.

¹⁴³*Informed Consent*, *supra* note 2, at 1662.

¹⁴⁴*Id.* at 1649.

¹⁴⁵Rice, *Euthanasia: A Time to Live and A Time to Die—How Physicians Feel*, *PSYCHOLOGY TODAY*, Sept. 1974 at 29 [hereinafter cited as Rice].

¹⁴⁶Reinhold, *supra* note 138.

¹⁴⁷Whittingham, *supra* note 1.

¹⁴⁸Dempsey, *Who Shall Live...and Who Shall Die?*, *Chicago Daily News*, Oct. 19, 1974, at 19.

¹⁴⁹Whittingham, *supra* note 1.

presence."¹⁵⁰ Thus, doctors usually follow the route of doing everything within their power to prolong life.¹⁵¹ That is how they are psychologically oriented: to "win."¹⁵²

Yet what of the best interest of the patients as the patient himself views it? That should be the primary duty of the physician when he acts. Indeed, there is evidence to show that a majority of the American public want to be able to tell their doctors to let them die if they are suffering from an incurable disease. Of those sampled in a 1973 Harris Poll, 62% favored this approach, while 28% felt it was wrong and 10% were undecided.¹⁵³ And in a Gallup Poll, 52% said they would support a law to end a patient's life by some painless means, at his request or that of his family, if he had an incurable disease.¹⁵⁴ The result of that poll certainly represented a change of attitude, for in 1950 only 36% thought a doctor should be allowed to induce painless death for an incurable patient if that patient or his family so requested.¹⁵⁵

There is also evidence, however, that doctors themselves may be changing their own attitudes toward euthanasia. Surprisingly, in a survey reported in mid-1974, 79% of physicians responding expressed some belief in the right of the patient to have a say about his death.¹⁵⁶ The subject of death has also become an important part of medical school curriculum, whereas in the past there was a tendency to neglect it in other than a strictly clinical sense.¹⁵⁷ Moreover, at its annual conference, the austere American Medical Association formally adopted the following policy statement: "The cessation of the employment of extraordinary means to prolong the life of the body where there is irrefutable evidence that biological death is imminent is the decision of the patient and-or his immediate family...." This provided doctors with a sanction for what many had actually been doing for some time, since the practice of turning off machines, for example, to allow death to come to a patient whom only the machine is keeping alive is a fairly common practice for hospitals.¹⁵⁸ As a matter of fact, doctors at the Yale University School of Medicine willingly acknowledged that they had quietly allowed 43 severely deformed infants to die by withholding treatment after the parents agreed there was little chance for "meaningful life." The doctors disclosed this in hopes of breaking down "a major social taboo."¹⁵⁹

Returning to the physician's poll mentioned above, what objections there were to euthanasia seemed to be based on religious grounds rather

¹⁵⁰*Informed Consent*, *supra* note 2, at 1658.

¹⁵¹Snider, *supra* note 7.

¹⁵²*Informed Consent*, *supra* note 2, at 1648.

¹⁵³*Id.* at 1649, 1658; Whittingham, *supra* note 1.

¹⁵⁴*Informed Consent*, *supra* note 2, at 1658.

¹⁵⁵Reinhold, *supra* note 138.

¹⁵⁶Rice, *supra* note 145, at 29.

¹⁵⁷Reinhold, *supra* note 138, at 1.

¹⁵⁸Whittingham, *supra* note 1.

¹⁵⁹Reinhold, *supra* note 138, at 1.

than on the major specialties or age groups of the responding doctors. Of the 933 doctors who answered the questionnaire, those with no religious affiliation were most likely to be found among the 20% who totally agree that patients should "have a right to choose how they die by making their wishes known to their physicians before serious illness strikes." (Overall, 38% in the random sample agreed with that in most cases, and another 21% agreed in some cases.) However, Catholics were the least likely to accept the idea that a patient had a right to influence his own death. Likewise, when asked what they would do "if ... a member of your family were suffering from terminal illness, which you as a physician knew carried little or no hope for survival"—a question to which nearly two-thirds reacted by saying that would "take no heroic measures" to keep the patient alive, most Catholic doctors opted for keeping the patient alive; among those 11% who would resort to the positive action of ending the suffering (euthanasia, of course), two-thirds were either Jewish or without religion.¹⁶⁰

The position of Catholic theologians has been that a doctor is obliged to take all ordinary means, including those medicines and treatments which can be used without causing unnecessary pain or expense (as may be coincident with the legal obligation to exercise due care), in order to preserve a patient's life; but this excludes any extraordinary means.¹⁶¹ The Vatican has now issued an authoritative statement on the ethics of mercy killing and the parameters within which it shall be acceptable. A majority of other churches in the United States have also subscribed to similar points of view.¹⁶² Furthermore, last year a Jesuit priest, Father Richard G. McCormick of the Kennedy Center for Bioethics at Georgetown University, proposed that grossly deformed infants should be allowed to die if their "potential for human relationship...is simply non-existent or would be utterly submerged and undeveloped in the mere struggle to survive." Father McCormick noted that though modern medicine has increased the power to preserve life, with that has come the added responsibility to make judgements about the quality of life to be saved. To that end, he has proposed the following guidelines "that may help in the decision about sustaining...lives": the individual decision to end life of such infants must be borne by the parents in consultation with their doctor, and the decision should only be made in terms of what is good for the child. He also offered some caveats, allowing that mistakes will be made because human decisions are involved and cautioning that the death of these infants does not imply that some lives are more valuable than others or that there is such a thing as a life not worth living. Still, Father McCormick concludes, "It is neither inhuman nor un-Christian to say that there comes a point where an individual's condition itself represents

¹⁶⁰Rice, *supra* note 145, at 29-30.

¹⁶¹Kutner, *supra* note 5, at 548.

¹⁶²Whittingham, *supra* note 1.

the negation of any truly human potential."¹⁶³

It has been asserted that the Judeo-Christian ethic forbids taking a life—even if that life will irreversibly end in painful death.¹⁶⁴ But some theologians claim that forms of religion stressing the promise of life after death merely use religion for selfish purposes. "This enormous emphasis on immortality," announced Krister Stendahl, Dean of Divinity at Harvard University, "was not in Judaism or early Christianity...." Perhaps, now there will be a return to a purer form of religion based simply on faith in God. At any rate, theologians are giving new attention to what human mortality means and they are raising those long neglected questions over the real purpose of human existence.¹⁶⁵

New Standards of Ethics—A Right to Die

Out of society's concern for preserving human life, the state may feel justified in forbidding voluntary euthanasia. After all, the underlying values of our society and Constitution uphold the right to life—and its protection is basic to any legal system. That is the prime justification, in fact, for the state's existence, according to Hobbes. However, it may well be argued that to forbid voluntary euthanasia is an infringement of the constitutionally recognized right of privacy, as derived from the 4th or 9th Amendments or the due process clause of the 5th Amendment.¹⁶⁶ In the interest of privacy, society ought to opt for an approach that will encourage self-determination, for voluntary euthanasia is not espoused merely as a relief for pain; rather, it is to preserve for the terminal patient his last meaningful freedom: control over the time of his death. Certainly, in such a case, there is the same right of self-determination for death as there is for life.¹⁶⁷

Strangely enough, though, given our advocacy of man's free will and the constitutional rights of the individual, he cannot relieve his suffering when all hope for recovery is lost.¹⁶⁸ Glanville Williams, the strong proponent of voluntary euthanasia, held there was a human freedom to end one's life. He contended that the law could not forbid conduct that, albeit undesirable, did not adversely affect the social order.¹⁶⁹ This view was similar to that advanced by John Stuart Mill, who based his concept of freedom of choice on instances which had a direct adverse effect on no one but the decision-maker himself.¹⁷⁰ "Each is a proper guardian of his own health, whether bodily or mental or spiritual," wrote Mill. "Mankind are

¹⁶³Hausner, *Jesuit Backs Mercy Death for Grossly Deformed Babies*, Chicago Daily News, July 8, 1974, at 38.

¹⁶⁴Whittingham, *supra* note 1.

¹⁶⁵Reinhold, *supra* note 138, at 1.

¹⁶⁶Kutner, *supra* note 5, at 539, 545.

¹⁶⁷*Informed Consent*, *supra* note 2, at 1657-58.

¹⁶⁸Whittingham, *supra* note 1.

¹⁶⁹Kutner, *supra* note 5, at 545.

¹⁷⁰*Informed Consent*, *supra* note 2, at 1643-44.

great gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest." And for Mill, "the sole end for which mankind are warranted...in interfering with liberty of action..., is self-protection."¹⁷¹ But Mill did make an exception to his doctrine of an individual's sovereignty over his own mind and body by applying it to the mature only, since he did not feel a child or young person not yet of age legally should be asked to make such life and death decisions; the minor was to be under the protection of the state.¹⁷²

In the conflict that arises between the right of the competent terminal patient to time his own death and the right of society to prolong death in the interest of perserving life, there is, of course, disagreement over whether society owes any reimbursement to the terminal patient and his family for the full costs of being deprived his right to timing his own death. But, granting the competent terminal patient the choice of when he shall die need not conflict with society's concern to preserve life. Such a patient who prefers a more rapid end should not have a continuation of life forced upon him. The sanctity of life is not an absolute concept which implies that society should deny the decision of a terminal patient who elects euthanasia. That decision should really include both alternatives of euthanasia—passive, for a prolonged death, or active, for a quicker death—in order to allow the maximum choice of timing death so that the patient will maintain what he regards as his dignity.¹⁷³

THE LIVING WILL

When an individual patient has no desire to be kept in a state of complete and indefinite vegetated animation with no possibility of recovering his mental and physical faculties, that individual, while still in control of all his faculties and his ability to express himself, could still retain the right of privacy over his body in determining whether he should be permitted to die by way of a document known as a "living will,"¹⁷⁴ providing

¹⁷¹J. S. MILL, ON LIBERTY 6, 8 (People's ed. 1873).

¹⁷²Marcus, *supra* note 10, at 1252.

¹⁷³*Informed Consent*, *supra* note 2, at 1658, 1650.

¹⁷⁴A typical living will may read as follows:

I, _____, of the City of _____, State of _____, U.S.A., Declarant, being of sound mind and disposing memory, herewith make this, my LIVING WILL, to be effective upon the following conditions:

That when an event occurs wherein it appears that I am physically or physiologically irreversibly ill, maimed or disabled, I request that a NON-JUDICIAL BOARD be convened comprised of three duly accredited Doctors of Medicine, a member of the Clergy of my faith (_____), and two lay persons;

That after total evidence has been presented to my irreversible conditions, and under my constitutional rights and my right to determine the integrity of my person, I then direct and request that I be given any appropriate method of EUTHANASIA. In so doing, I hold harmless and exonerate the members of my EUTHANASIA BOARD, individually and collectively;

That in the event legislation is in force authorizing the existence and func-

revoke the document; and, because statements or actions subsequent to the written document might indicate contrary consent, if the maker of the will is subsequently adjudged incompetent, the will would also be revoked (though the revocation would not apply where incompetency resulted from a medical condition contemplated in making the decision). The approach of the living will here is analogous to the concept of a revocable or conditional trust, with the patient's body as the *res*, the patient himself as the beneficiary and grantor, and the doctor and hospital as trustees. The doctor is given authority to act as trustee of the patient's body by virtue of the patient's consent to treatment. But the patient, as grantor, is free at any time to revoke that trust relationship created between him and the doctor. In creating the document, it is the intent of the patient to cover contingencies wherein he would be able to grant or withhold consent to treatment. That would include incompetency due to mental illness. Mental illness might present a problem to the concept of the living will, but the mentally ill patient has the same rights as any other patient. So, *via* the will, an individual may anticipate mental illness and limit his consent to treatment accordingly. If, in the course of that illness, the patient enters an incurable comatose state, treatment may cease. The problem might arise in that a court may find the patient, upon becoming mentally ill, to be incompetent and appoint a guardian for him. Still, the will would remain in effect; the guardian could not nullify it. Sometimes mentally ill patients have moments when their minds are lucid. During such instances, he might indicate to his guardian or physician if he wishes the will revoked and the guardian could then act accordingly to revoke the will.

To those who feel that living wills are too vague to offer any confidence in the adequacy of their safeguards, it might be pointed out that these documents could be individually tailored to mitigate some of the uncertainties as to the actual intent under particular circumstances.¹⁷⁷ A Jehovah's Witness, opposed to blood transfusions on religious principles, could so provide in such a document. A Christian Scientist could indicate he does not wish any medical treatment through such a document.

Further, living wills can only be made by adults capable of giving their consent—patients who have a right to decide whether they will receive treatment. That does not apply to minors, those institutionalized or adjudged incompetent. Nor could a parent acting on behalf of his child make such a declaration, so that while an adult patient may himself refuse to undergo an operation or receive a blood transfusion to save his life, a parent could not deprive a child of such treatment.

As long as public policy does not condone euthanasia, the living will may still be used as a means to direct a doctor to act passively through inaction (thereby permitting the patient to die) in much the same way a patient may refuse to sign the legal statement required to indicate his consent to undergo surgery or other treatment.

¹⁷⁷*Informed Consent*, *supra* note 2, at 1664.