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The Foundations of the Right to Die

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THE FOUNDATIONS OF THE RIGHT TO DIE

But in this world nothing can be said to be certain, except death and taxes.¹

I. INTRODUCTION

The certainty of both death and taxes remains as true today as when Benjamin Franklin remarked upon them in 1789. A change has occurred, however, in the way in which individuals and the medical and legal professions perceive death.

Advancements in medical technology have enabled the medical profession to extend and sustain life far beyond the boundaries of what was previously thought possible. The consequences of these advancements have raised novel problems which have been only partially resolved. The ability to transplant organs initiated some of the first problems faced by the medical and legal professions. The probability of success in the organ transplant was increased if the organ was infused with oxygen; but under the traditional definition of death, the cessation of respiration and pulsation,² a person whose respiration and circulation were maintained by artificial means was alive regardless of the loss of cognitive functions. Physicians faced the possibility of civil liability for wrongful death or criminal liability for homicide for the “death” of the donor body. They were “forced to work not only at the edge of medical knowledge but also at the edge of the law.”³ This problem was resolved by nationwide acceptance of the Uniform Anatomical Gift Act of 1968⁴ and by a change in the definition of death itself.

A problem still in the process of being resolved involves the right of individuals to control their own fate in the context of medical

¹ Letter from Benjamin Franklin to Jean Baptiste LeRoy (Nov. 13, 1789), reprinted in The Oxford Dictionary of Quotations, 211:9 (2d ed. 1953).
² Black's Law Dictionary 488 (4th ed. 1968); Known as the “heart-lung" definition of death, D. Meyers, Medico-Legal Implications of Death and Dying, § 3.1 at 17 (1981); [hereinafter cited as Death and Dying].
⁴ Death and Dying, supra note 2, § 17.10 at 529.
advances by refusing all forms of medical treatment, even to the point of death. This has come to be popularly tagged as the "right to die with dignity" unencumbered by intrusive and unwanted intervention. This article will survey the common law, constitutional, and statutory bases of an individual's "right to die with dignity" and the cases discussing the extent of an individual's right to do so, including the refusal or withdrawal of nutrition and hydration.

The definition of death has evolved within the last twenty years. Thus, it is important to gain a preliminary understanding of the present legal and medical definitions of death.

II. THE DEFINITION OF DEATH

A. The Traditional Definition

The "heart-lung" definition of death was expressed by Black's Law Dictionary as "[t]he cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation...thereon, such as respiration, pulsation, etc." In short, when an individual no longer breathed and there was no heart beat, the person was dead. This led to strained results, as evidenced by a 1952 Kentucky case in which a decapitated woman was said to have survived her husband "for a fleeting moment" because blood was gushing from her neck. The limitations inherent in the definition, in light of medical advances and the possible liability connected with organ transplantation, provided the catalyst for a new legal definition of when life ceased—brain death.

B. Brain Death

The uniformly accepted definition of brain death, judicially and legislatively, is total cessation of all brain functions, including functions of the brain stem.  

7 Death and Dying, supra note 2, § 4.3 at 27 (citing Black's Law Dictionary); Lovato v. District Court, In And For The Tenth Judicial Dist., 148 Colo. 419, 601 P.2d 1072, 1076 (1979).
Some jurisdictions have judicially adopted the brain death standard, usually in connection with criminal cases. A representative example is an Arizona court's decision rejecting a criminal defendant's contention that termination of life support systems caused the victim's death rather than five gunshot wounds. The court recognized that under the traditional definition, the victim was not dead when the life support systems were removed because "the body of the victim was breathing, though not spontaneously, and blood was pulsating through his body . . . ." The Arizona court found, however, that the gunshot wounds were the proximate cause of death and that the victim "was legally dead before the life support systems were withdrawn." The court concluded that brain death, "if properly supported by expert medical testimony, is . . . a valid test for death in Arizona," reasoning that the physicians "passively stepp[ed] aside to let the natural course of events lead from brain death to common law death."  

Thirty-five states and the District of Columbia have adopted a statutory definition of brain death. Twenty-five states and the District of Columbia provide a choice between the "heart-lung" definition or the brain death definition. Eight states allow use of the

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8 State v. Fierro, 124 Ariz. 182, 184, 603 P.2d 74, 76 (1979).  
9 Id. at 185, 603 P.2d at 77.  
10 Id.  
11 Id. at 186, 603 P.2d at 78.  

(a) Determination of death. - An individual is dead if, based on ordinary standards of

One factor shared by all adoptions of the brain death definition is the traditional interplay of the medical and legal professions. The medical profession establishes the criteria for death, but the actual definition of death is legally determined, either judicially or statutorily.

\section{C. The Usefulness and Limitations of the Brain Death Definition}

The definition of death as cessation of brain functions has solved some of the problems originally faced by the medical and legal professions. There is now no doubt that the cause of death in a criminal case is the criminal act and not the removal of artificial medical practice, the individual has sustained either:

(1) Irreversible cessation of circulatory and respiratory functions; or
(2) Irreversible cessation of all functions of the entire brain, including the brain stem.


\footnote{\textit{\copyright} Ill. Ann. Stat. ch. 110 1/2, para. 302 (Smith Hurd 1978); W. Va. Code § 16-10-2 (1985). An example of this category is West Virginia's statute: Brain Death. For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain is dead. A determination under this section must be made in accordance with reasonable medical standards.}

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support systems from a brain dead victim. Physicians can now transplant organs from legally dead persons whose respiratory and circulatory functions are maintained by artificial means without fear of liability. The brain death definition does not, however, address the problem of the individual who has suffered partial brain death.

Three frequent causes of partial brain death include traumatic injuries to the head, spontaneous brain hemorrhages, and deprivation of oxygenated blood flow to the brain.\textsuperscript{15} The brain dies in stages when deprived of oxygen. Deprivation for a period of four to six minutes is sufficient to cause irreversible loss of function to the cerebral cortex, the portion of the brain which controls the processes of thought, emotion, and consciousness. Deprivation of oxygen for ten to twenty minutes will result in death of the brain stem, the more primitive portion of the brain which controls respiration, heart rate, and blood pressure. While the cortex may suffer irreversible loss of function after four to six minutes of oxygen deprivation, the brain stem may remain unaffected.\textsuperscript{16} "[A] patient may well be rendered unconscious, and incapable of recovering consciousness, and any capacity for thought, emotion, and intellectual perception, but may have the ability to spontaneously breathe and maintain pulse and circulation."\textsuperscript{17} Thus, other judicial applications and statutory measures have been necessary to respond to the problems resulting when an individual or a representative of an incompetent individual exercises the right to refuse medical treatment in this situation and in others akin to it.

III. The Right to Refuse Medical Treatment

The right to refuse medical treatment or intervention has three legal bases: common law, constitutional, and statutory. The interplay of these three bases provides the foundation from which individuals or their representatives have exercised the "right to die with dignity."

\textsuperscript{15} De\textsuperscript{ath} and Dying \textit{supra} note 2, § 4.2 at 25 (citing Hir\textsuperscript{sh}, Med. Tr. Tech. Q. 377, 379 (1975).

\textsuperscript{16} Id.

\textsuperscript{17} Id.
A. The Common Law Basis

The right of an individual to bodily integrity is well-established in the common law. The United States Supreme Court recognized this established principle in 1891. A plaintiff in a personal injury action refused to submit to the medical examination requested by the defendants, and the court held in conclusive terms that she had the right to refuse. "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." 18

Common law held medical treatment to be an invasion of bodily integrity that required the consent of the patient. Judge Cardozo succinctly stated this principle in 1914. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages." 19 Under the doctrine of informed consent, the physician is required to give sufficient information to the patient so that he understands his condition, prognosis, and the risks and benefits of alternatives, including no treatment. The patient must be capable of voluntarily making a reasoned judgment regarding alternative treatments or no treatment. 20 The corollary of informed consent is the right to refuse any medical treatment whatsoever.

Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception. 21

Although the common law is a strong and viable basis for the right to refuse medical treatment, the first court to squarely face the prob-

lem of the termination of treatment of a mechanically maintained individual decided the question on constitutional grounds.

B. The Constitutional Right of Privacy

Karen Ann Quinlan had been in a coma and her breathing had been maintained by a respirator for approximately one year when her father, Joseph Quinlan, petitioned the New Jersey court for appointment as her guardian with express power to terminate the extraordinary medical procedures sustaining her vital functions. Joseph Quinlan relied upon the following three claimed constitutional rights to exercise this power: an independent parental right to exercise freedom of religion, protection against cruel and unusual punishment, and the right of privacy. The court refused to recognize an "independent parental right of religious freedom to support the relief requested" and also termed the situation religious neutral, raising no constitutional religious question. The Constitution's eighth amendment protection against cruel and unusual punishment was also held inapplicable in this case because it applied only to penal sanctions or punishment inflicted by state or law. The assertion of Karen's constitutional right of privacy, however, was accepted by the court.

Recognition of the right of privacy has expanded during the same time period in which technological medical advances have raised problems connected with death and individual rights. The United States Supreme Court recognized the existence of the right of privacy in penumbras of the Bill of Rights in Griswold v. Connecticut in 1965. Griswold was concerned with contraception, the intimate relationship between husband and wife, and "the physician's role in one aspect of that relation." The Court held that such relationships were "within the zone of privacy created by several fundamental

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23 Id. at 22, 355 A.2d at 653.
24 Id. at 37, 355 A.2d at 661-62.
25 Id. at 38, 355 A.2d at 662.
26 Id. at 40-41, 355 A.2d at 663-64.
28 Id. at 482.
constitutional guarantees."29 In 1973, the Supreme Court held that
the right of privacy was "broad enough to encompass a woman's
decision whether or not to terminate her pregnancy.30 The Court
observed that this penumbral right had possibly been recognized by
the Supreme Court in 1891 in Union Pacific Ry. Co. v. Botsford31
and that decisions have extended this right "to activities relating to
marriage, procreation, contraception, family relationships, and child
rearing and education."32 The New Jersey court in Quinlan inter-
preted the areas covered by the Supreme Court's privacy decisions
as interdictions of "judicial intrusion into many aspects of personal
decision" and extrapolated from previous decisions an evolutionary
application of the right of privacy to "a patient's decision to decline
medical treatment under certain circumstances."33 Karen Quinlan,
if competent, could have decided to remove the life support system
"even if it meant the prospect of natural death" and that right was
not destroyed by her incompetency.34

The right of privacy exists, but it is not absolute.35 Balanced
against the individual's right of privacy are countervailing state in-
terests. Recognized state interests are the preservation and sanctity
of human life, maintenance of the ethical integrity of the medical
profession, prevention of suicide, and protection of innocent third
parties.36 The court used a balancing test in Quinlan to determine
whether the state's interests outweighed the individual's right of pri-
vacy. Setting the standard for future cases, this balancing test em-
ployed such factors as the prognosis, the degree of bodily invasion,
and the possibility of resumption of cognitive life. "[T]he State's interest . . . weakens and the individual's right to privacy grows as
the degree of bodily invasion increases and the prognosis dims. Ul-

29 Id. at 485.
31 Id. at 152; see supra, text accompanying note 18 (common law right to bodily integrity).
32 Roe, 410 U.S. at 152-53 (citations omitted).
33 Quinlan, 70 N.J. at 40, 355 A.2d at 663.
34 Id. at 40, 355 A.2d at 664.
35 Roe, 410 U.S. at 154.
36 Quinlan, 70 N.J. at 40, 355 A.2d at 663; Conroy, 98 N.J. at 348-49, 486 A.2d at 1223; Satz
timely there comes a point at which the individual’s rights over-come the State interest.\textsuperscript{37}

The New Jersey court’s analysis of the countervailing state’s in-terests also set a standard that proved to be a guidelines for future cases, particularly on the integrity of the medical profession. Karen Quinlan’s attending physicians were correct in refusing to withdraw the respirator according “to the then existing medical standards and practices.”\textsuperscript{38} These standards and practices were not, however, an “ineluctable bar” to granting Joseph Quinlan’s petition.\textsuperscript{39} Physicians differentiate between “curing the ill and comforting and easing the dying” and “refuse to treat the curable as if they were dying or ought to die, and . . . they have sometimes refused to treat the hopeless and dying as if they were curable.”\textsuperscript{40} The court concluded that “the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as dis-tinguished from the forced continuance of . . . biological vegetative existence.”\textsuperscript{41}

The common law and the constitutional right of privacy provide powerful support for individuals, competent and incompetent, in the assertion of their right to control their own bodies and resist un-wanted bodily invasions. The wide publicity the Quinlan case re-ceived in 1976 dramatically brought to lay, legal, and legislative attention the problems inherent with advancing medical technology and the exercise of individual rights. The legislative response was enactment of natural death acts.

\begin{itemize}
\item C. The Natural Death Acts
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Thirty-seven states and the District of Columbia have adopted some form of a natural death act, under various names, allowing termination of mechanical or artificial life-prolonging measures in
certain circumstances.\footnote{42} Although the acts are not identical, they are usually structurally similar. The following four basic provisions are found in most of the acts: a set of definitions, a procedure for executing a living will, a procedure for revoking a living will,\footnote{43} and immunity to health care providers. West Virginia’s Natural Death Act\footnote{44} will be employed as a beginning reference in the consideration of the provisions discussed, with comments on other states’ statutes included for comparison and differing provisions.

1. Definitions

In the majority of state acts, provisions allowing termination of artificial or mechanical means of treatment under some circumstances are limited by statutory definitions. The West Virginia act defines attending physician, declaration (living will), life-sustaining procedure, physician, qualified patient, and terminal condition. As in most natural death acts, the most restrictive definitions are found for life-sustaining procedure, qualified patient, and terminal condition.


\footnote{43} A written declaration directing the withholding or withdrawal of medical treatment in specified circumstances.

\footnote{44} W. Va. Code § 16-30-1 to -10 (1986).
a. Life-sustaining Procedure

A life-sustaining procedure is "any medical procedure or intervention which, when applied to a qualified patient, would serve only to artificially prolong the dying process and where, in the judgment of the attending physician and a second physician, death will occur whether or not such procedure or intervention is utilized." The restrictions of this definition are obvious. It is not the nature of the medical procedure which determines whether it is a "life-sustaining procedure," but rather to whom and in what stage of illness it is applied, a "qualified patient" engaged in an incurable "dying process." This is the essence of most states' definitions of a life-sustaining procedure, although the name used may be life support system, maintenance medical treatment, life-prolonging procedure, artificial life-prolonging procedure, or extraordinary means. State statutes which do specify the nature of the procedure usually use wording similar to that in Florida's Life-Prolonging Procedures Act: "[A]ny medical procedure, treatment, or intervention which: (a) Utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function." This is always only a portion of the definition, the other portion containing the "qualified patient" and "dying process" restrictions. New Mexico's anomalous statutory definition of life-sustaining procedure is much broader and, therefore, less restrictive. It simply defines "maintenance medical treatment" as "medical treatment designed solely to sustain the life processes.

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45 Id. §§ 16-30-1 to -10 (1986).
47 DEL. CODE ANN. tit. 16, § 2501(d) (1983). "[U]tilizes mechanical or other artificial means to sustain, restore or supplant a vital function . . . artificially prolonging] the dying process."
48 FLA. STAT. ANN. § 765.03(3) (West 1986).
50 MO. ANN. STAT. § 459.010(3)(Vernon 1983).
52 FLA. STAT. ANN. § 765.01 to .15 (1986).
53 Id. § 763.03(3) (1986).
54 N.M. STAT. ANN. § 24-7-2(C) (1986).
West Virginia's definition of life-sustaining procedure further restricts the withdrawal or termination of a life-sustaining procedure by excluding from the definition "the administration of medication or the performance of any medical procedure deemed necessary to provide comfort, care or to alleviate pain." This exclusion of the administration of medication and procedures to provide comfort, care and alleviate pain is common, although not universal. Some acts are more restrictive and also specifically exclude the administration of foods or fluids, also called nutrition, sustenance, and hydration. West Virginia does not specifically exclude nutrition and hydration in its definition of life-sustaining procedure. However, the statutory form of the written declaration to withdraw life-sustaining procedures (hereinafter referred to as "living will") provides "that I be permitted to die naturally with only the administration of nutrition, medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain." The statute states that "[t]he declaration shall be substantially" in the form set forth in the Code but "may include other specific directions not inconsistent with other provisions of this article." This would appear to encompass nutrition within the exclusion from withdrawal of "any medical procedure deemed necessary to provide comfort, care or to alleviate pain."

Two states specifically include nutrition and hydration in measures that may be withdrawn or withheld. Tennessee's Right to Natural Death Act distinguishes between medical treatment to diagnose,

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55 W. Va. Code § 16-30-2(3) (1985). West Virginia's wording of this exclusion is unique. Every other statute that has a similar exclusion states "comfort care or to alleviate pain" rather than West Virginia's statement "comfort, care or to alleviate pain."


58 Id. (emphasis added).

assess, or treat a patient ("medical care") and measures taken primarily for the patient's comfort ("palliative care"). Both may be withdrawn from a qualified patient, and both specifically include forms of nutrition and hydration. The Alaska Living Will Act provides a choice between provision or withdrawal of nutrition in its suggested form for a living will. Both of these inclusions are limited by other statutory provisions and definitions of qualified patient and terminal condition.

b. Qualified Patient

Almost all natural death acts have a definition for a qualified patient, i.e., one from whom life-sustaining procedures may be withheld or withdrawn. These definitions usually have only two elements. The patient must have executed a living will in accordance with the statute, and the patient must be certified by a statutorily determined number of physicians to be in a terminal condition. West Virginia defines a qualified patient as:

'Qualified patient' means a patient who has executed a declaration in accordance with this article and who has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom is the attending physician: Provided, that if there be more than one attending physician, all such attending physicians must certify in writing that the patient is afflicted with a terminal condition.

The definitions for qualified patients and life-sustaining procedures must be read with the definition for terminal condition in order to understand the entirety of the restrictions on eligibility for the "right to die" under the natural death acts.

c. Terminal Condition

The terminal condition definition contained in natural death acts usually has at least four elements: (1) incurable or irreversible con-

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60 Id. § 32-11-103(5) & (6) (Supp. 1985).
61 Id. §§ 32-11-102(a) & 32-11-104(a) (Supp. 1985).
63 ALASKA STAT. §§ 18.12.010 to -.100 (1986).
64 Id. § 18.12.010 (1986).
condition; (2) condition caused by injury, disease, or illness; (3) there is no possibility of recovery, or natural death would result regardless of the application of life-sustaining procedures; and (4) death is imminent, would occur within a short period of time, or the moment of death is merely postponed by the application of life-sustaining procedures.

West Virginia defines terminal condition as "an incurable condition caused by injury, disease or illness, which, regardless of the application of life-sustaining procedures, would . . . cause natural death and where the application of life-sustaining procedures serves only to postpone the moment of death." The definition appears to be slightly less restrictive than that of some states in that it contains no requirement that death must occur within a short period of time or that death must be imminent. Wisconsin's requirement that the terminal condition must cause the death of a qualified patient within thirty days is probably the most specific and restrictive of the definitional qualifications for coverage under a natural death act.

Further restrictions in the acts are found in the form through which individuals may exercise the right to withhold or withdraw life-sustaining procedures.

2. Living Wills

In defining "qualified patient," the requirement of execution of a living will is usually included. The living will expresses the desire of the patient that his or her dying not be prolonged by life-sustaining procedures, and it directs the withholding or withdrawal of such procedures in the event that the declarant becomes incompetent (unable to express his or her desires) and in a terminal condition. Most acts provide mandatory or optional forms for the living will.

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66 Id. § 16-30-2(6) (1985).
67 See generally ALASKA STAT. § 18.12.100(7) (1986); MO. ANN. STAT. § 459.010(3) (Vernon Supp. 1987).
68 CAL. HEALTH AND SAFETY CODE § 7187(c) (Deering Supp. 1987).
The formal requirements to be adhered to in the execution of a testamentary will are also adhered to in most states to restrict the class of persons qualified to execute the living will and the procedures to be followed during such execution. The declarant, for example, must be of legal age and of sound mind. Most acts also contain a presumption that the declarant making a living will was competent when the document was executed.

The legal procedure most often formulated by the natural death acts requires that the document be in writing, signed by the declarant or at his or her direction in the declarant’s presence, dated, and signed in the presence of at least two witnesses of legal age. The acts also specify those not qualified to serve as witnesses. This exclusion usually applies to persons who have signed the living will for the declarant at his or her direction, persons related by blood or marriage to the declarant or who may have an interest in the declarant’s estate, and persons who are responsible for the declarant’s medical expenses. Also commonly excluded are employees of the health care institution in which the declarant is a patient. The signatures and attestations of the witnesses must be notarized.

All statutes provide for revocation procedures which are more lenient and informal than provisions for execution of the living will. A living will can be revoked by destroying the document, by a revocation document signed and dated, or by oral expression to a witness of legal age who signs and dates a writing. Only the declarant or someone acting at the declarant’s direction can revoke the living will. The acts uniformly provide that a qualified patient’s

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70 See generally W. VA. CODE § 16-30-3(a) & (d) (1985); UTAH CODE ANN. § 75-2-1104(1) & (4) (Supp. 1987); IOWA CODE ANN. § 144A.3(1) (West Supp. 1986); TENN. CODE ANN. § 32-11-104(a); MD. HEALTH-GEN. CODE ANN. § 5-602(a) (Supp. 1986).
71 See generally W. VA. CODE § 16-30-6(b) (1985); UTAH CODE ANN. § 75-2-1113 (Supp. 1987).
72 See generally W. VA. CODE § 16-30-3(a) (1985); GA. CODE ANN. § 31-32-3(a) (1985).
74 See generally W. VA. CODE § 16-30-3(b)(5) (1985); TENN. CODE ANN. § 32-11-104(a) (Supp. 1985); UTAH CODE ANN. § 75-2-1104(3)(c) (Supp. 1987).
77 See generally W. VA. CODE § 16-30-4(a) (1985); GA. CODE ANN. § 31-32-3(a) (1985).
desires supersede the living will at all times regardless of the patient’s mental condition. If an attending physician has been notified of the existence of a living will for a qualified patient, the revocation of the document must be communicated to the physician.

3. Immunity to Health Care Providers

All acts afford a health care provider with legal immunity for withdrawing or withholding life-sustaining procedures in accordance with the statutory provisions. All that is usually required of the health care provider is that the action be in good faith.

4. Other Provisions

Most acts contain various provisions other than those discussed above relating to the legal effects of the acts or the rights of the declarant. Although these other clauses of the natural death acts differ in form, detail, inclusion, and frequency, they can be divided into general categories.

a. Insurance

Provisions regarding insurance and the effect of an insured person signing a living will are frequently considered in the natural death acts. The insurance clauses usually contain two sections, one relating to the effect on life insurance and one to the effect on health care insurance.

A declarant cannot be denied a life insurance policy because he or she has executed a living will. A life insurance policy is not modified, legally impaired or invalidated by the execution of a living will or the withdrawal or withholding of life-sustaining procedures from an insured declarant, regardless of the policy terms. A person

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cannot be required to execute a living will as a precondition or prerequisite to obtaining health care insurance from an insurer.\(^8\)

b. Penalties

Penalties are imposed by a majority of the acts for withholding or forging a living will or a revocation. A distinction is frequently made between situations in which a person acts contrary to the declarant's intent by continuing life-sustaining procedures and situations in which a person acts to discontinue life-sustaining procedures. A comparison of the penalties imposed by the statutes of three states demonstrates the range of penalties imposed and the distinction drawn between the two situations. When a person conceals or destroys a living will or forges a revocation of a living will so that procedures are continued, Utah, West Virginia and New Mexico impose penalties as follows:

Utah — Offense is a class A misdemeanor\(^8\)

West Virginia — Offense is a felony punishable by a fine of up to $5,000 and/or imprisonment for up to three years\(^8\)

New Mexico — Offense is a third degree felony punishable by a fine of $5,000 and/or imprisonment for two to ten years.\(^8\)

By comparison, penalties for forging a living will or destroying a revocation of a living will so that procedures are withdrawn are:

Utah — Offense is criminal homicide\(^8\)

West Virginia — Offense is a felony punishable by imprisonment for one to five years\(^8\)

\(^8\) Id. § 16-30-8(c) (1985).
\(^8\) W. Va. Code § 16-30-7(c) (1985).
\(^8\) N.M. Stat. Ann. § 24-7-10(B) (1986).
\(^8\) Utah Code Ann. § 75-2-1115(2) (Supp. 1986).
New Mexico — Offense is a second degree felony punishable by imprisonment for ten to fifty years and/or a fine of $10,000.88

Iowa is one of the few states with no distinction between the acts. Under the Iowa statute, a person who acts either to continue or withdraw life-sustaining procedures illegally is guilty of a "serious misdemeanor."89

Alaska imposes a civil penalty upon health care providers who fail to comply with a directive to withhold or withdraw life-sustaining procedures. A physician who knowingly refuses to follow such directive has "no right to compensation for medical services after withdrawal would have been effective" and is subject to a fine of $1000 in addition to the actual costs of failing to comply.90

c. Suicide, Homicide, and Euthanasia

Another frequent provision of the natural death acts states that withdrawal or withholding of life-sustaining procedures does not constitute suicide or homicide for any legal purpose.91 Obviously, the construction against suicide applies mainly to life insurance and that against homicide to the immunity from liability provided by the acts to persons involved with removal of life-sustaining procedures.

The statements in the acts pertaining to euthanasia, in contrast, are based upon a legislative concern that the natural death acts may be extended further than intended. The West Virginia statute devotes a separate section of its Natural Death Act to euthanasia, tellingly entitled "Prohibition."92 Its language is fairly typical of that found in other acts: "Nothing in this article may be construed to condone, authorize or approve mercy killing or to permit any affirmative or

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88 N.M. STAT. ANN. § 24-7-10(A) (1986).
89 IOWA CODE ANN. § 144A.10 (West Supp. 1986).
91 See generally IOWA CODE ANN. § 144A.11(1) (West Supp. 1986); N. M. STAT. ANN. § 24-7-8(A) (1986); W. VA. CODE § 16-30-8(g) (1985); ALASKA STAT. § 18.12.080(a) (1986).
92 W. VA. CODE § 16-30-10 (1985).
deliberate act or omission to end a human life other than to permit the natural process of dying as provided in this article.” This typically worded provision is reminiscent of the language used in cases judicially recognizing brain death. The implication is that the natural death acts are merely evolutionary statements in light of modern medical technology, allowing health care providers to step aside, by removing or withholding life-sustaining procedures, with immunity to permit natural death to take place. In this sense, the natural death acts are extensions of the reasoning that brought brain death to wide acceptance.

Georgia’s statute contains a subsection under “Effect of chapter on other legal rights and duties” similar to West Virginia’s “Prohibition,” but Georgia adds a unique expression of legislative intent. After tracking the language quoted above, Georgia continues: “Furthermore, nothing in this chapter shall be construed to condone, authorize, or approve abortion.” The Georgia legislature apparently wanted to ensure that two areas encompassed by the right of privacy were not united by analogous reasoning, a situation arising in a case which will be considered later.

d. Transfer of Patients

If withholding or withdrawing life-sustaining procedures is unacceptable to a physician or a health care provider, the natural death acts commonly provide an alternative. If a physician is unwilling or if it is against the policies of a health care provider to comply with the directions of a living will, then the physician or provider is to transfer the patient to another physician or facility where the declaration of the patient will be honored. This provision recognizes the impact of an individual’s exercise of a controversial right on others who may find the required actions repugnant.

93 Id.
95 See generally W. VA. CODE § 16-30-7(b) (1985); IOWA CODE ANN. § 144A.8 (West Supp. 1986).
e. Preservation of Existing Rights

Twenty-four states and the District of Columbia have a provision in their natural death acts specifically stating that the statutory rights of the acts are cumulative with any preexisting rights the individual might have. For example, West Virginia’s preservation clause provides:

Nothing in this article impairs or supersedes any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this article are cumulative.

The natural death acts, in general, apply only in certain circumscribed situations. The acts containing preservation clauses appear to state that any rights belonging to an individual before enactment of the statute remain unaffected by the statute. There is a possibility that common law rights of individuals in the states whose acts do not have a preservation clause are limited to some extent by enactment of the statutes. The difference, however, may be more illusory than real.

Florida has a broad and specific preservation of existing rights section that the Florida appellate court construed in a case litigating the withdrawal of nutrition and hydration from an incompetent pa-


The provisions of sections 765.01—765.15 are cumulative to the existing law regarding an individual's right to consent, or refuse to consent, to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor or incompetent patient, or a patient's family may have in regard to the withholding or withdrawal of life-prolonging medical procedures under the common law or statutes of
Florida specifically excludes withdrawal of nutrition and hydration from life-sustaining procedures which may be withdrawn under its natural death act. Withdrawal of nutrition and hydration was allowed because the act was "supplemental to existing rights and laws." The preservation clause "protect[ed] all constitutional rights a patient might have or else the statute would be unconstitutional." Even if there were no such clause in the statute, "[t]he right protected is a constitutional right which could not be limited by legislation."

Any apparent infringement on the common law by natural death acts without a preservation clause is probably nonexistent since the patient's rights could be asserted under the constitutional basis.

f. Pregnancy

Thirteen states have sections dealing with the pregnant qualified patient. Life-sustaining procedures will not be withdrawn or withheld in compliance with a living will from a pregnant qualified patient during the pregnancy or as long as it is probable that the fetus could develop to birth.

g. No Living Will Executed

There are two provisions found in the natural death acts which consider the effect of the absence of an executed living will on a qualified patient. A common approach provides that no presumption of the patient’s intent is created when the patient has not executed

100 Id. at 372.
101 Id. at 370.
102 Id. at 372.
a living will.\textsuperscript{104} If an incompetent patient in a terminal condition has not made a living will, the absence of the document cannot be used to create a presumption that the patient desired either the continuation or withdrawal of life-sustaining procedures.

Nine states have statutory procedures to be followed if a qualified patient has not executed a living will.\textsuperscript{105} The first qualification in these sections is that the person must be a qualified patient, usually in a terminal, irreversible condition and comatose or unable to communicate. The statutes generally specify that the attending physician can determine whether the patient is qualified, but Oregon and North Carolina require confirmation of the patient’s condition by other physicians.\textsuperscript{106}

Safeguards are incorporated into the sections by the requirements for the decision-making procedure. Typically, the attending physician and one set of classes of individuals, listed in the order of priority in the statutes, consult and agree in writing that life-sustaining procedures should be removed from the qualified patient, guided by the express or implied intentions of the patient. Classes included in the acts are judicially appointed guardians, attorneys-in-fact, persons designated in writing by the patient to make treatment decisions for him or her if the patient is incompetent, the patient’s spouse, adult child or a majority of adult children, parents, and nearest living relatives. The priority and members of the classes vary from act to act. Frequently one or two witnesses are required to the agreement between the attending physician and the acting class.

New Mexico’s section allows “maintenance medical treatment” to be removed from the qualified patient after a physician has sat-

\textsuperscript{104} See generally IOWA CODE ANN. § 144A.11(4) (West Supp. 1986); MD. HEALTH-GENERAL CODE ANN. § 5-610(2) (1985); W. VA. CODE § 16-30-9(b) (1985) (West Virginia’s provision states “to the use of withholding of life-sustaining procedures,” which is probably a typographical error. The usual language provides “to the use or withholding of life-sustaining procedures.”).

\textsuperscript{105} IOWA CODE ANN. § 144A.7 (West Supp. 1986); FLA. STAT. ANN. § 765.07 (West 1986); LA. REV. STAT. ANN. § 40-1299.58.5 (West 1985); N.C. GEN. STAT. § 90-322 (1985); OR. REV. STAT. § 97.083 (1985); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon 1983); IOWA CODE ANN. § 144A.7 (West Supp. 1986); VA. CODE ANN. § 54-325.8:6 (1983); N.M. REV. STAT. ANN. § 24-7-8.1 (1984).

\textsuperscript{106} OR. REV. STAT. § 97.083(1)(b) (1983); N.C. GEN. STAT. § 90-322(b) (1985).
satisfied two requirements. First, the physician must use reasonable diligence to contact all family members available. Second, the family members must agree “in good faith that the patient, if competent, would choose to forego that treatment.”

Oregon’s statute is also anomalous in one respect. If none of the classes listed is available to make a decision, life-sustaining procedures may be removed under the direction of a physician. Oregon, however, has more stringent requirements for a qualified patient than do other states when no declaration has been executed. As noted above, a committee of physicians, with the attending physician excluded, must certify the patient’s condition.

h. Special Power of Attorney

The special power of attorney allows an individual to designate another person to make health care treatment decisions if the individual becomes incompetent. In Florida’s statute, one of the classes of others in the section “Procedure in the absence of a declaration” is “person(s) designated by the patient in writing to make treatment decisions for him should he be diagnosed as suffering from a terminal condition.” Utah’s natural death act contains a separate section for the power of attorney and a mandatory form for the document. Utah requires that the person designated to act as an attorney-in-fact be an adult, and the power of attorney is effective only when the principal is “unable to give current directions” because of his or her physical or mental condition.

A durable power of attorney, which is similar to a special power of attorney, is statutorily provided for in some other states. However, the durable power of attorney does not specifically provide for decisions by an attorney-in-fact in medical situations. It is

109 FLA. STAT. ANN. § 765.07(1)(b) (West 1986).
111 Id. § 75-2-1106(1) (1985).
112 DEATH AND DYING, supra note 2, § 16.10 at 195 (Supp. 1986).
113 See W. VA. CODE § 39-4-1 to -7 (Supp. 1986).
unclear whether it could legally be used to withhold or withdraw any form of medical treatment absent a plain declaration of legislative intent that it could indeed be so used. This is particularly true considering the narrowly drawn nature of the natural death acts.

i. Patients in Nursing Home Facilities

Four states and the District of Columbia have special requirements for witnessing a living will executed by a patient in a nursing home facility. The obvious intent is to safeguard this type of protected patient. Colorado excludes other patients or residents of the health care facility as witnesses. Delaware and the District of Columbia require that one of the witnesses to the living will be a patient advocate or ombudsman. In addition to two witnesses to the living will, Georgia requires that the chief of the hospital medical staff or the medical director be a witness.

5. The Effect of the Natural Death Acts

Generally, the natural death acts are narrowly drawn. They apply only to the incompetent patient in a terminal, irreversible, incurable condition who would die regardless of life-sustaining procedures and who, with the exceptions noted, has executed a living will while competent. The publicity about the plight of Karen Ann Quinlan provided the catalyst for these acts, but the irony is that she would not have been a qualified patient under the statutes’ definitions. The natural death acts, with one exception, do not address the patient who is incurably comatose but whose brain stem continues to function.

The exception is New Mexico’s Right to Die statute. New Mexico’s act provides that an adult of sound mind may execute a living
will directing that "maintenance medical treatment" not be used to prolong his or her life if the adult is "suffering from a terminal illness or ... [is] in an irreversible coma."119 "Irreversible coma" is defined as "that state in which brainstem functions remain but the major components of the cerebrum are irreversibly destroyed."120 "Maintenance medical treatment" is defined as "medical treatment designed solely to sustain the life processes."121 "Terminal illness" is defined as "an illness that will result in death . . . regardless of the use or discontinuance of maintenance medical treatment."122 There is no requirement that death occur within a short time or imminently, or that the treatment only prolong the dying process. The broad scope of the language of this statute would seem to cover most contingencies short of assisted suicide and euthanasia.

IV. THE COURTS AND TERMINATION OF LIFE-SUSTAINING TREATMENT

Quinlan was the seminal case in judicial consideration of the termination of medical treatment. It was important not only for its substantive holdings but also because it set the pattern of analysis for future cases.

A. The Pattern of Analysis

1. The Factual Basis

The factual background is the beginning of all judicial considerations of the right to refuse medical treatment. The factors considered are the competency or incompetency of the patient, the physical condition and prognosis of the patient, and the presence or absence of any written or verbal prior expression of intent by the patient.

119 Id. § 24-7-3(A) (1984).
120 Id. § 24-7-2(B) (1984).
121 Id. § 24-7-2(C) (1984).
122 Id. § 24-7-2(F) (1984).
2. The Rights of the Individual

The legal analysis begins with a determination of the bases for the assertion of the rights of the individual. Common law, constitutional law, and statutory rights are analyzed, in varying combinations.

The New York Court of Appeals has held that consideration of the common law alone was sufficient. The court refused to reach any constitutional questions since relief was "adequately supported by common law principles."\(^\text{123}\)

The New Jersey Supreme Court based its decision on constitutional principles, without considering the common law, holding that the penumbral right of privacy in the Bill of Rights and in New Jersey's Constitution encompassed the right to refuse medical treatment and that the right was not destroyed by the individual's incompetency.\(^\text{124}\) The Supreme Court of Washington analyzed the application of the penumbral right of privacy in the United States Constitution in more detail, using a traditional constitutional analysis of application through the fourteenth amendment.\(^\text{125}\) The court listed the following four state actions which created a "sufficient nexus between the state and the prohibitions against withholding or discontinuance of life sustaining treatment":\(^\text{126}\) The state had the power to impose "criminal sanctions on the hospital and its staff", the state licensed physicians, the judiciary was required to be involved in appointment of a guardian, and the state had a "parens patria responsibility to supervise the affairs of incompetents."\(^\text{127}\)

Enactment of the natural death acts has added little to the analysis of the rights of an individual in cases brought before the courts. Execution of a living will usually gives the court only a concrete expression of an incompetent patient's wishes regarding artificial medical treatment. The Supreme Court of Florida called the living will "persuasive evidence of [an] incompetent patient's decision,"

\(^\text{124}\) Quinlan, 70 N.J. at 41, 355 A.2d at 663, 664.
\(^\text{125}\) Colyer, 99 Wash.2d at 121, 660 P.2d at 742.
\(^\text{126}\) Id.
\(^\text{127}\) Id.
but the court also held that its primary use was to guide "the person or persons who substitute their judgment on behalf of the terminally ill incompetent." With that construction, the natural death acts and the execution of a living will appear to be more useful in the factual basis as expressive of prior intent than as determinative of the rights of individuals.

3. The Countervailing State Interests

The right to refuse medical treatment encompassed by the right of privacy must be balanced against state interests. The state interests commonly identified are the preservation and sanctity of human life, prevention of suicide, maintaining the ethical integrity of the medical profession, and protection of innocent third parties. The preservation and sanctity of human life is probably the most important state interest advanced. Apparently in contemplation of this interest, a majority of the courts has rejected any analysis of the individual's "quality of life" as a factor to be considered in decisions allowing or forbidding termination of treatment.129

Prevention of suicide is sometimes reasoned to be subsumed in the state's interest in the preservation and sanctity of human life. The Quinlan court, in its discussion of the preservation and sanctity of human life, drew a distinction between an act of self-destruction and one of self-determination.130 The Massachusetts court observed in 1977 that a patient exercising his or her right of medical self-determination "may not have the specific intent to die," and even if the patient did have that specific intent, refusal of medical treatment would lead to death from natural causes, not from suicide.131 "[T]he patient did not set the death producing agent in motion with the intent of causing his own death."132 This analysis has been widely

130 Quinlan, 70 N.J. at 43, 355 A.2d at 655.
131 Saikewicz, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11.
132 Id.
used by the courts when discussing the state's interests in preserving life and preventing suicide.

Maintenance of the ethical integrity of the medical profession received its most extensive analysis in *Quinlan*. Judicial decisions after *Quinlan* tend to quote most of the language used and rather summarily discount this state interest. It has not proved to be an "ineluctable bar" to any court's decision to allow termination of medical treatment. A Catholic hospital, with "a strong institutional policy" against participating in the withholding of foods or fluids from a patient, brought a court action to compel a competent, terminally ill patient to leave the hospital because she had decided to refuse artificial feeding. The court refused to grant the relief requested. The burdens to be incurred by the patient if she were compelled to move outweighed the burdens on the hospital if she were allowed to remain there until her death. The court stated that "judges should not defer to hospital decisions which are unreasonable or which improperly burden patients or impair patient rights."  

A California hospital refused to remove a ventilator and restraints from a competent patient, who had delivered a living will, a signed declaration, a durable power of attorney, and releases from the family. The hospital based its refusal on the following four grounds: (1) the patient was not in a terminal condition; (2) the patient had vacillated about his decision, frantically motioning for the ventilator to be reconnected when a tube was accidentally detached, and had made inconsistent statements; (3) the institution was a Christian hospital and disconnecting the ventilator was unethical; and (4) the health care providers were concerned about liability. The trial court refused to issue an injunction against the hospital because there was a potential for "cognitive, sapient life." The appellate court held that the trial court erred, stating, "[I]f the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests

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134 *Id.* at 488, 517 A.2d at 893.
136 *Id.* at 192, 209 Cal. Rptr. at 223.
of the patient's hospital and doctors." The patient was competent to make the decision and occasional vacillation did not make his competency questionable. As examples of the judiciary's willingness to maintain the ethical integrity of the medical profession, these two cases are probably not extreme examples.

The theory behind the state's interest in protecting third parties is that "the patient's exercise of his free choice could adversely and directly affect the health, safety, or security or others." This interest rarely plays any major role in a court's analysis of termination of medical treatment. This is primarily because the patients involved are usually elderly, in a terminal or irreversible condition, have no minor children, and the spouse, children, or nearest relative is usually the petitioner. There is no "innocent third party" adversely affected by the exercise of the individual's rights, and the exercise of those rights would not create a "public health or safety hazard."

4. The Decision-Maker

If a patient is competent, no question arises as to who has the right to make treatment decisions. The Quinlan court immediately recognized that Karen Ann Quinlan, if competent and aware of her hopeless condition, "could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death." Ten years later the New Jersey Superior Court stated, with very little analysis, that it was "absolutely clear" that a competent patient had a legal right to refuse to be artificially fed even though it meant an earlier death.

If a patient is incompetent, however, a representative must exercise the patient's right to determine his or her own treatment. The Quinlan court placed the decision-making power with the family,

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137 Id. at 195, 209 Cal. Rptr. at 225, 227.
138 Id. at 193, 209 Cal. Rptr. at 223, 224.
139 Conroy, 98 N.J. at 353, 486 A.2d at 1225.
140 Id. at 355, 486 A.2d 1226.
141 Quinlan, 70 N.J. at 39, 355 A.2d at 663.
142 Requena, 213 N.J. Super. at 479, 517 A.2d at 888.
with qualifications. The family, using its best judgment, was to decide whether the patient would have exercised her constitutional right of privacy to have the respirator removed. The pattern which has developed in cases considering termination of artificial medical treatment has followed Quinlan and is frequently called "substituted judgment." "[T]he goal is to determine with as much accuracy as possible the wants and needs of the individual involved." The patients are safeguarded from possible abusive exercises of substituted judgment by procedures set forth by the courts.

5. Procedure for Decision-Making

The New Jersey Supreme Court set up a three-tiered process of decision-making for incompetent patients. The attending physician must first conclude "that there is no reasonable possibility of [the patient's return] ... to a cognitive, sapient state and that the life-support apparatus ... should be discontinued." The person who asserts the patient's right to terminate treatment, usually the spouse or next of kin, is to use his or her best judgment as to what the patient would have wanted, with general concurrence by the patient's guardian, if any, and the family. The Quinlan court called for the formation of an Ethics Committee at hospitals or institutions. The function of the Ethics Committee is to assist and safeguard the interests of the patient and the medical personnel, screening out unworthy motivations and diffusing responsibility for the decision. The Ethics Committee, in effect, reviews the prognosis for the patient; and if the committee agrees that no reasonable possibility exists that the patient will return to a cognitive, sapient state, then the life-support system may be withdrawn. The court did not require judicial approval of the decision.

Other states have insisted on their own forms of safeguarding procedures. For example, the Washington Supreme Court required

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143 Quinlan, 70 N.J. at 41, 355 A.2d at 664.
145 Saikewicz, 373 Mass. at 750, 370 N.E.2d at 430.
146 Quinlan, 70 N.J. at 54, 355 A.2d at 671.
147 Id. at 50, 54, 355 A.2d at 664, 671.
148 Id. at 55, 355 A.2d at 671.
that a “prognosis board” unanimously concur that “there is no reasonable medical probability of returning to a cognitive, sapient state.” A guardian for the incompetent patient and a guardian ad litem to represent the patient’s best interest in any court proceedings would be appointed by the court before any decision was made. The court would intervene further in the decision-making process only if the prognosis board could not agree or if “a court determination of the rights and wishes of the incompetent” was required. Massachusetts requires a much more active role for the courts. A guardian and a guardian ad litem are appointed; all viewpoints are argued in front of a judge; and the judge issues an order regarding the treatment. This procedure appears to result in judicial substituted judgment. The Massachusetts court later held that prior judicial approval was not necessary in every case, but it did not make clear in what cases judicial approval was not needed. It seems unlikely that health care providers will act without prior court approval.

B. The Effect of Prior Verbal and Written Expressions of Intent

One of the most important aspects of the courts’ analyses in deciding to withhold or continue life-support maintenance of patients is the consideration of how the patients would choose to exercise their right of self-determination. In Quinlan, evidence was submitted to the trial court that Karen, when competent, had verbally stated that she would not wish her life prolonged by extraordinary means. The trial court rejected this evidence as lacking “significant probative weight” because it was remote and impersonal, and the New Jersey Supreme Court agreed. The court later declared that it was in error in rejecting this evidence. When a patient has previously expressed an intent to refuse some forms of

149 Colyer, 99 Wash.2d at 136, 660 P.2d at 749-50.
150 Id. at 137, 660 P.2d at 750-51.
151 Salkewicz, 373 Mass. at 756-57, 370 N.E.2d at 433-34.
152 Spring, 380 Mass. at 642, 405 N.E.2d at 120-21.
153 Quinlan, 70 N.J. at 22, 355 A.2d at 653.
154 Conroy, 98 N.J. at 362, 486 A.2d at 1230.
medical treatment upon the occurrence of some contingent physical condition, the expression of intent has almost become the determinative factor in judicial decisions to allow termination of artificial medical treatment.\textsuperscript{155}

Factors providing guidelines for the probative value of prior verbal expressions were discussed in \textit{Eichner v. Dillon}.\textsuperscript{156} Brother Fox, an eighty-three year old member of a religious order, suffered brain damage during an operation. While the \textit{Quinlan} case was receiving wide publicity, his religious order held formal discussions about the moral principles involved. Brother Fox stated then that he agreed with Catholic principles permitting “termination of extraordinary life support systems when there is no reasonable hope for... recovery” and that “he would not want any of this ‘extraordinary business’ done for him under those circumstances.”\textsuperscript{157} A few months before his operation, he reiterated those views. When his religious superior petitioned the court for removal of the respirator maintaining Brother Fox’s breathing, the court held that the level of proof for evidence of the patient’s intent was “clear and convincing.”\textsuperscript{158} Evidence of Brother Fox’s prior statements met that burden. His religious beliefs supported the conclusion that Brother Fox had carefully reflected on his expressed views. The only motive of the witnesses who testified regarding those expressions was to see that Brother Fox’s wishes were fulfilled. His expressions were “solemn pronouncements and not casual remarks.”\textsuperscript{159} Brother Fox was old enough to “realize or feel the consequences of his statement.”\textsuperscript{160} He reiterated his decision shortly before he became incompetent, and his physical state was identical to that of Karen Ann Quinlan, which had “prompted his decision.”\textsuperscript{161}

In a 1984 Florida case, an incompetent, terminally ill patient had executed a living will; and the hospital, fearing liability, sought ju-

\textsuperscript{156} Eichner, 52 N.Y.2d at 363, 420 N.E.2d at 64, 438 N.Y.S.2d at 266.
\textsuperscript{157} Id. at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.
\textsuperscript{158} Id. at 378-79, 420 N.E.2d at 72, 438 N.Y.S.2d at 72, 438 N.Y.S.2d at 274.
\textsuperscript{159} Id. at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.
\textsuperscript{160} Id.
\textsuperscript{161} Id.
dicial determination of its rights and liabilities. The district court affirmed the trial court’s requirement of court approval of termination of medical procedures, holding that a “mercy will” could not be equated with the capability of a competent patient to exercise his right of privacy. The “mercy will” could be introduced into evidence as the “best evidence of the patient’s intention,” but the district court also required that due execution of the will and the mental capacity of the patient be proved by testimony or affidavit.

The Florida Supreme Court quashed the decision of the district court. The court held that judicial approval of termination of treatment was not required, the decision should be made in the “patient-doctor-family relationship” using substituted judgment, and a “living” or “mercy” will was “persuasive evidence of [the] incompetent person’s intention.”

A prior expression of intent, whether verbal or written, is typically determinative of a patient’s choice in terminating treatment. It is analogous to the dead man’s hand behind a will; the patient speaks from beyond incompetency as the testator does from beyond the grave. It appears to be relatively uncommon now for a life-support system to be continued when there is a prior expression of intent in opposition by the patient.

C. When There Is No Expression of Prior Intent

A person who becomes incompetent, is incurable, terminal, or comatose, and who has never expressed any preference regarding medical procedures is in much the same situation as Karen Ann Quinlan. Substitute judgment, determining as nearly as possible what the patient would have decided, is used in much the same way as it was in the Quinlan case.

The Massachusetts Judicial Supreme Court, using its substituted judgment procedure, allowed termination of hemodialysis treatments for a senile patient suffering from “end-stage kidney disease.”

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162 Bludworth, 452 So.2d at 922.
163 Id. at 923.
164 Id. at 926.
165 Spring, 380 Mass. at 632, 405 N.E.2d at 118.
The court affirmed use of substituted judgment to exercise an incompetent’s right to be “free from nonconsensual invasion of . . . bodily integrity.” Hemodialysis was a greater invasion of bodily integrity than orally or intravenously administered medications, and the patient was incapable of understanding the need for treatment. The treatments were “life-prolonging rather than life-saving,” and the court found that the patient would have chosen not to receive the treatment if he were competent and aware of his condition.

Sandra Foody aspirated while eating, suffered brain damage, and lapsed into a semicomatose state, breathing with the assistance of a respirator. She had never expressed any desires about her treatment if she were ever in this state. Her parents brought an injunctive action against the hospital for the discontinuance of the life-support system maintaining her respiration and pulse. Because her prognosis was poor, the treatment intrusive, and the benefits of the treatment to her minimal, the Connecticut Superior Court held that her right to terminate the life-support systems could be exercised by her parents through substituted judgment.

The Foody court succinctly stated the principle generally used by the courts when an incompetent patient has not made known his or her choice. “An expression of intent while competent is not essential, the opinion may be based upon knowledge of the individual from a family relationship.”

D. The Patient Who Was Never Competent

The situation with a patient who has always been incompetent is different than those considered above. There can usually be no prior expressions of desires regarding medical treatment, and it is
difficult or impossible to determine what the person would have decided if competent. The two cases considered in this category concern profoundly retarded individuals.

Joseph Saikewicz was 67 years old, suffering from leukemia, and a resident of state institutions for 54 years. The institution petitioned for a guardian to be appointed for him so that medical decisions could be made. The guardian ad litem recommended that he not undergo chemotherapy because Saikewicz was unable to understand the treatment, and the resulting fear and discomfort would outweigh the "possibility of some uncertain but limited extension of life." The Massachusetts Supreme Judicial Court again used the substitute judgment doctrine, but tailored it to the facts of the case. The decision "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." Factors weighing against the administration of chemotherapy were the patient’s inability to cooperate in his treatment, his age, the suffering and side effects caused by the treatment, and the prognosis with the treatment. The court rejected quality of life as a factor insofar as it "demeans the value of the life of one who is mentally retarded." Mr. Saikewicz had the same substantive rights "to decline potentially life-prolonging treatment" as a competent person, and the court decided that, considering all the factors, he would elect to enforce his "right to privacy and self-determination."

The mother of a profoundly retarded, institutionalized man suffering from terminal cancer of the bladder refused to permit transfusions to counteract the possibly terminal bleeding caused by the cancer. The New York Court of Appeals decided that it was unrealistic to try to determine what the patient’s decision concerning

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172 Saikewicz, 373 Mass. at 731, 370 N.E.2d at 420.
173 Id. at 730, 370 N.E.2d at 419.
174 Id. at 752-53, 370 N.E.2d at 431.
175 Id. at 754, 370 N.E.2d at 432.
176 Id. at 736, 370 N.E.2d at 423.
177 Id. at 759, 370 N.E.2d at 435.
the treatment would be if he were competent. Instead, the court noted that "[m]entally John Storar was an infant and that is the only realistic way to assess his rights." \(^{179}\) Whether to allow or deny the transfusions was analyzed on a parent-child basis. A parent has the right to consent to the medical treatment of his or her child but does not have the right to decline treatment when the child's life is endangered. The latter was the situation encountered by the court in this case. The patient could bleed to death if he was not transfused. The transfusions were not excessively intrusive, and his physical and mental conditions were affected when he was not transfused. The court recognized the complications engendered by two serious illnesses; the transfusions would not cure the cancer, but they could "eliminate the risk of death from another treatable cause." \(^{180}\) The transfusions were allowed to be administered.

The court in \textit{Storar} used the same analysis as that used in other termination of treatment cases, but it was based on a determination of the mother's rights in the situation instead of the incompetent adult's rights. Although not specifically articulated, the incompetent adult in this case was placed by the court in the position of an innocent third party who could be harmed by the exercise of the mother's rights. The presence of the potentially harmed innocent third party tipped the scales in favor of prevention of the exercise of the individual's rights (the mother's) in the balancing test.

The two lines of analysis used when a patient has never been competent, substituted judgment and parent-child, employ a benefits versus burdens of treatment analysis to decide the results. The prognosis of the patient's condition and the intrusiveness of the procedure, particularly considering the patient's inability to comprehend, are major factors in both analyses; the analysis itself is in the familiar pattern set by \textit{Quinlan}. If the treatment in question in \textit{Storar} had been for the cancer, the result may have been different.

\textbf{E. Nutrition and Hydration}

One situation not discussed in the previous cases concerns the person who has sufficient brain stem function to be capable of
breathing without the aid of artificial means. Such an individual has been known to linger in a comatose vegetative state for up to thirty-seven years.\footnote{Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E.2d 626, 637 (1986).} A solution that recently has been employed is to withhold nutrition and hydration, food and water, from the comatose individual to allow him to die.

Nutrition and hydration are not administered to comatose patients in the normal manner of ingestion. Instead, nutrients and fluids are fed into the patient’s body through tubes. There is controversy over whether nutrition and hydration administered by this method qualify as medical treatment which can be refused. To many, withdrawal appears to be an unattractive form of euthanasia. The Massachusetts Supreme Judicial Court drew a distinction between “those situations in which the withholding of extraordinary measures may be viewed as allowing the disease to take its natural course and those in which the same actions may be deemed to have been the cause of death.”\footnote{Id. at 158.} The Massachusetts court called this a “subtle distinction,”\footnote{In re Severns, 425 A.2d 156, 157 (Del. Ch. 1980).} and the subtlety is sometimes lost when the issue is withholding nutrition and hydration.

1. The First Cases

Probably the first case to hold that nutrition and hydration could be withdrawn from an incompetent patient was decided in 1980 in Delaware. A woman who suffered upper brain damage in an automobile accident was able to breathe without mechanical assistance and received nourishment from a nasogastric tube.\footnote{Id.} Her husband requested an order from the Delaware court directing her health care providers to refrain from acting if her condition worsened, including refraining from surgical procedure to place a feeding tube in her trachea.\footnote{Id. at 158.} Evidence was presented that she had stated she “did not want to be kept alive in a vegetative state,” that she was a former member of the Delaware Euthanasia Education Council, and that
she had not signed a living will only because of her husband's reluctance to reciprocate. The court used the Quinlan analysis, recognizing the effect of the right of privacy in medical decisions and the opposing state interests. The requested relief was granted. No known medical procedures would cure or restore the patient; and, the court observed, the distinction between ordinary and extraordinary medical care blurs when a person is "in an apparently non-reversible vegetative state." Apparently the nasogastric tube was left in place, but no surgical procedures were to be performed if some other kind of feeding device became necessary.

In 1983 two physicians in California were charged with murder and conspiracy to commit murder because they had agreed with a patient's family to remove the tubes providing nutrition and hydration to the patient. The physicians filed writs of prohibition with the California court, and the court concluded that the physicians' conduct, even "though intentional and with knowledge that the patient would die, was not an unlawful failure to perform a legal duty." In reaching this conclusion, the court considered the rights of the patient and the nature of the treatment. Administration of nutrition and hydration was viewed as being the same as mechanical life-support equipment, manual injections, or medication. It was "more similar to other medical procedures than to typical human ways of providing nutrition and hydration." The administration of nutrition and hydration would not cure the patient or alleviate his condition, and the physicians did not have a duty to continue ineffective treatment. The court enunciated guidelines for the continuance of treatment. It rejected the distinction between ordinary and extraordinary treatment, favoring instead a benefits versus burdens of treatment standard, the benefits of the treatment outweighing the burdens if the patient's life was lengthened under acceptable conditions. As usual, the paramount consideration in

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186 Id.
187 Id.
189 Id. at 1022, 195 Cal. Rptr. at 493.
190 Id. at 1016-17, 195 Cal. Rptr. at 490.
191 Id. at 1017, 195 Cal. Rptr. at 490-91.
192 Id. at 1019, 195 Cal. Rptr. at 491.
any decision is the patient’s interests and desires; and a surrogate could exercise the patient’s right to choose, guided by “the patient’s best interests.”

In re Hier,194 decided in 1984, involved a 92 year old psychotic patient unable to ingest food by mouth who was fed through a gastronomy tube, which she repeatedly pulled out. She eventually refused to allow the tube to be reinserted, and the nursing home petitioned for appointment of a guardian to make medical judgments for her. The Massachusetts Appeals Court applied the substituted judgment doctrine and agreed that the patient, if competent, would reject surgery to reinsert the tube.195 Factors considered were the burden and intrusiveness of the surgery, the patient’s objections, the decreased benefits of the treatment because of the patient’s lack of cooperation, and the concurrence of the patient’s physicians. The court refused to draw a distinction between nutrition and other medical treatments.196

A severely demented nursing home patient, who had “no higher functioning or consciousness” but some response to her surroundings, was the subject of a 1985 New Jersey case involving removal of a nasogastric tube.197 The Appellate Division refused to allow removal of the tube. Such an action would “hasten death rather than simply allow the illness to take its natural course . . . . [W]ithdrawal of [the] nasogastric tube would be tantamount to killing her — not simply letting her die — and . . . such active euthanasia was ethically impermissible.”198 On appeal, the New Jersey Supreme Court expressly rejected assessment of another’s quality of life as a basis for decision-making; instead the “primary focus should be the patient’s desires and experience of pain and enjoyment - not the type of treatment involved.”199 Also expressly rejected were dis-

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193 Id. at 1021, 195 Cal. Rptr. at 492-93.
196 Id. at 964.
197 Conroy, 98 N.J. at 338, 486 A.2d at 1216-17.
198 Id. at 341-42, 486 A.2d at 1219.
199 Id. at 369, 486 A.2d at 1232-33.
tinctions between actively terminating treatment and passively allowing an individual to die naturally,\textsuperscript{200} between withholding and withdrawing treatment, between ordinary and extraordinary treatment,\textsuperscript{201} and between terminating artificial sustenance and other medical procedures.\textsuperscript{202} Artificial sustenance supplied through "nasogastric tubes, gastronomies, and intravenous infusions . . . are medical procedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning."\textsuperscript{203} The patient, "if competent to make the decision and if resolute in her determination, could have chosen to have her nasogastric tube withdrawn,"\textsuperscript{204} and an incompetent patient has the same right as a competent patient to reject "any medical treatment, including artificial feeding."\textsuperscript{205} However, the nursing home patient in this case, a member of a protected class, would not have met the tests the court set out for the exercise of the rights of a patient in a nursing home situation.

2. The 1986 Cases

In 1986, five cases involving issues of rejecting or withdrawing nutrition and hydration were decided. All of the jurisdictions had previously considered cases involving termination of some form of artificial medical maintenance treatment.\textsuperscript{206}

In California, Elizabeth Bouvia, a bedridden quadriplegic afflicted with cerebral palsy and crippling arthritis, petitioned the court to remove a nasogastric tube which had been inserted without her consent.\textsuperscript{207} In 1983, the California courts had refused to allow her to starve herself to death in a public hospital, and her current health care providers were concerned that she was again attempting suicide.

\textsuperscript{200} Id. at 369, 486 A.2d at 1233-34.
\textsuperscript{201} Id. at 369-70, 486 A.2d at 1234.
\textsuperscript{202} Id. at 372-73, 486 A.2d at 1236.
\textsuperscript{203} Id. at 373, 486 A.2d at 1236.
\textsuperscript{204} Id. at 355, 486 A.2d at 1226.
\textsuperscript{205} Id. at 374, 486 A.2d at 1236.
\textsuperscript{206} California, Florida, Massachusetts, New York and New Jersey.
\textsuperscript{207} Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1134, 1136, 225 Cal. Rptr. 297, 300
The trial court agreed with the health care providers that she was again attempting suicide, but the appellate court disagreed. The court concluded that the common-law basis of self-determination gave an adult of sound mind "the right to refuse any medical treatment, even that which may save or prolong her life." The exercise of the "basic and fundamental" constitutional right of privacy "requires no one's approval. It is not merely one vote subject to being overridden by medical opinion." The California court, in contrast to the analysis of other courts, considered the quality of the patient's life significant. Because of Bouvia's condition, "the quality of her life [had] been diminished to the point of hopelessness, uselessness, unenjoyability and frustration." Her irreversible condition, future helplessness, and the consequences of her helplessness would make her life an ordeal; and under these conditions, "it [was]... immaterial that the removal of the nasogastric tube [would] hasten or cause Bouvia's eventual death." The appellate court held that the trial court had erred by considering the possible motives behind the patient's decision. "If a right exists, it matters not what 'motivates' its exercise," and the appellate court ordered the nasogastric tube removed.

Bouvia is a startling case, not so much because of the result, but for the strength of the language used and the extent of the right of privacy implied by the California court. When discussing the possible suicide motivation, the court stated that "a desire to terminate one's life is probably the ultimate exercise of one's right of privacy." The opinion is also surprising in its emphasis on the quality of life, an assessment expressly rejected by some courts in termination of treatment cases.

In re Requena, a New Jersey case, also involved a competent patient's desire to refuse a nasogastric tube; and the hospital in

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208 Id. at 1144, 225 Cal. Rptr. at 306.
209 Id. at 1137, 225 Cal. Rptr. at 300 (emphasis in original).
210 Id. at 1137, 225 Cal. Rptr. at 301.
211 Id. at 1142, 225 Cal. Rptr. at 304.
212 Id. at 1144, 225 Cal. Rptr. at 305.
213 Id. at 1145, 225 Cal. Rptr. at 306.
214 Id. at 1144, 225 Cal. Rptr. at 306.
which she was a patient brought this action to compel her to transfer to another hospital.\textsuperscript{215} There was no question in the New Jersey Superior Court's opinion that the patient had the legal right to refuse the nasogastric tube. Her action was not suicide because there was no "positive act to terminate life."\textsuperscript{216} Instead, her decision was an acceptance of and acquiescence in the natural process of dying reached after careful consideration and with an understanding of all the implications.\textsuperscript{217} The hospital contended that its "pro-life" policy forbade it to participate in "denying food and water to a patient."\textsuperscript{218} The court inferred that the hospital was confusing abortion issues with Requena's situation and stated that "[t]here is no sensible comparison to be drawn between the two situations."\textsuperscript{219} She had merely "accept[ed] death and... surrender[ed] to the dying process."\textsuperscript{220}

The health care providers in a Florida case sought a declaratory judgment regarding removal of a nasogastric tube from a 75 year-old patient in a permanent vegetative state.\textsuperscript{221} The trial court held that the right of privacy did not extend to withholding nutrition and hydration supplied through a nasogastric tube. The Florida Right to Decline Life-Prolonging Procedures Act specifically excluded nutrition and hydration from coverage. The district court held that the trial court had erred. The Florida natural death act "was not intended to encompass the entire spectrum of instances in which these privacy rights may be exercised."\textsuperscript{222} The preservation of rights section in the Florida act protected all constitutional rights, and the act itself applied only to a certain class of patients, those who wish to decline the statutorily-defined life-sustaining procedures. The court also found no distinction between forced artificial feeding and forced maintenance of vital functions. It concluded that "the right to have a nasogastric tube removed is a constitutionally protected right" in the circumstances of this case.\textsuperscript{223}
Massachusetts again considered the incompetent patient and the substituted judgment doctrine in *Brophy v. New England Sinai Hosp., Inc.* \(^{224}\) Brophy's wife brought a declaratory judgment action when the hospital refused to remove the gastronomy judgment tube supplying him with nutrients as his family had requested. The trial court found that Brophy would have wanted the tube removed because of the following factors: "(1) Brophy's expressed preferences; (2) his religious convictions and their relation to refusal of treatment; (3) the impact on his family; (4) the probability of adverse side effects; and (5) the prognosis, both with and without treatment." \(^{225}\) Despite the trial court's conclusion as to Brophy's choice if competent, it refused to order the discontinuance of the feeding tube. The Supreme Judicial Court of Massachusetts reversed the trial court, ordering the tube discontinued, but upheld the right of the hospital to refuse to participate in the removal. Mr. Brophy had made repeated emphatic statements that he would not want to be maintained by a life-support system. \(^{226}\) He was not terminally ill but was in a condition he would have considered demeaning and helpless. The court's view was that artificial feeding of the patient in this condition was "intrusive treatment as a matter of law." \(^{227}\) Since the court upheld the hospital's refusal to participate in removal of the feeding tube, the state's interest against violation of the ethical integrity of the medical profession was neutralized. \(^{228}\)

*Delio v. Westchester County Medical Center* was decided in a New York lower court on December 5, 1986. \(^{229}\) Daniel Delio, 33 years old, had an operation to repair an anorectal fistula. He emerged

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\(^{224}\) *Brophy*, 398 Mass. 417, 497 N.E.2d 626.

\(^{225}\) *Id.* at 497 N.E.2d at 631.

\(^{226}\) *Id.* at 497 N.E.2d at 632 n.22.

\(^{227}\) *Id.* at 497 N.E.2d at 636.

\(^{228}\) *Id.* at 497 N.E.2d at 638.

\(^{229}\) *Delio*, 134 Misc. 2d 206, 510 N.Y.S.2d 415. This decision was reversed June 1, 1987 by the Supreme Court, Appellate Division, of New York. The court emphasized the prior, unambiguous statements of the patient and the common law right of self-determination (refusing to reach any constitutional issue). The court rejected a distinction between artificial feeding and other forms of medical treatment and any distinction between the rights of individuals based on age or medical condition. Daniel Delio's common law right of self-determination outweighed the state's interests; and all medical treatment, including nutrition and hydration, could be discontinued. Delio v. Westchester Co. Medical Center, No. 98-1481E (N.Y. App. Div., June 1, 1987) (WESTLAW).
from the operation in a chronic vegetative state. He was capable of breathing without artificial assistance but was fed through a gastronomy tube. His wife and mother petitioned the New York court to direct the hospital, or some institution where Delio could be transferred, to stop all treatment including the provision of nutrition and hydration. Evidence was introduced, which met the clear and convincing burden of proof required by the New York courts, that Mr. Delio had occasionally "remarked that he never would want his life prolonged by artificial means if he were in a chronic vegetative state with no hope of recovery."²³⁰ The New York lower court distinguished the prior New York case, Eichner, in several particulars. Brother Fox was maintained by a respirator and Mr. Delio by a feeding tube. The respirator was a "more complex mechanism" than a "surgical attachment to... [the] abdomen of a tube for feeding purposes."²³¹ Removal of the respirator would cause death within a short time, while death resulting from the removal of the feeding tube could take days or weeks; and "[t]he furnishing of food and drink to the ill is traditional and symbolical of the duty commonly conceived to be due to a patient."²³² The court distinguished between the age and condition of Brother Fox, 83 and terminally ill, and that of Mr. Delio, 33 and in no danger of imminent death. The court implied that withholding nutrition and hydration was more appropriate for older, terminally ill persons than for younger, relatively healthy persons because of the possibility that advancements in medical technology could eventually cure the condition.²³³ One noticeable aspect of the opinion is the scant attention given to the common law and constitutional rights involved. Where, as in Delio, a jurisdiction lacks sufficient case law or legislative guidance, it is surprising that more analysis was not given to the individual's rights.

The New York lower court denied removal of the feeding tube but urged an appeal of the decision. It concluded the opinion with

²³⁰ Delio, 134 Misc. 2d, 510 N.Y.S.2d at 416.
²³¹ Id. at, 510 N.Y.S.2d at 417. The lower New York court in Delio has apparently returned to a distinction between ordinary (the feeding tube) and extraordinary (the respirator) care that other courts have discarded or downgraded.
²³² Id.
²³³ Id. at, 510 N.Y.S.2d at 418.
what was, perhaps, the true reasoning behind the holding. "[J]udicial activism in cases such as this . . . can only involve the courts in a yet unsanctioned broad scale policy of euthanasia."234

3. Future Projections

To date, only a handful of jurisdictions have decided cases involving termination of life-sustaining treatment or the withholding of nutrition and hydration. It is probable that the natural death acts will avert litigation in the narrow areas in which they apply; but as the court noted in Delio, "more and more Courts are being called upon to render decisions made necessary because of modern medicine's ability to postpone the dying process."235 As proof of this, more cases involving nutrition and hydration issues were decided in 1986 than had ever before been decided. It seems likely that more and more courts will be called upon to more clearly determine the parameters of the right of privacy.

Those jurisdictions without common law precedent or legislative direction appear likely to follow the pattern of analysis discussed in this article. It also appears probable that the courts will allow termination or withdrawal of artificial maintenance medical treatment, including nutrition and hydration, on the basis of the common law right of self-determination, the constitutional right of privacy, and the decisions made by patients or for patients through substituted judgment. The exercise of the right of privacy, as it is now interpreted, is difficult to neutralize by institutions or agents of governments advocating countervailing state interests. State legislative action appears unlikely to be effective in stemming this trend since the right involved is a basic and fundamental constitutional one involving private decisions about an intimate portion of life—dying.

West Virginia is a jurisdiction which has not considered the right of privacy and the refusal of medical treatment. It has, however, considered the right of privacy asserted by a prisoner against being force-fed while he was on a hunger strike.236 In considering the pris-

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234 Id. at , 510 N.Y.2d at 420.
235 Id. at , 510 N.Y.2d at 415.
oner's petition for a writ of prohibition against the prison officials, the West Virginia Supreme Court engaged in the familiar analysis of the individual's right of privacy balanced against the state's four claimed interests. In this instance, the state's interest in the preservation of life was "superior to [the prisoner's] personal privacy (severely modified by his incarceration)." The court commented, in dicta, on the right to refuse medical treatment. "Major decisions about this right deal with distinctly personal issues: rights of procreation and rights of death." Although West Virginia apparently excluded withdrawing or withholding nutrition in its statutory living will form, its preservation of existing rights clause guarantees the continuance of all previous rights, thus the common law principle of self-determination is not affected. Even if the common law has been changed by the natural death act, the state legislature could not change the constitutional basis for assertion of the right of privacy. Unless some circumstance weighed heavily in the balance for countervailing state interests, it would appear that termination of artificial maintenance medical treatment, including withdrawing or withholding nutrition and hydration, could be accomplished.

V. Conclusion

It hath been said, that it is not death, but dying, which is terrible. Within the last twenty years, technological advances have changed the meaning of death and of dying. The meaning of death went through a metamorphosis. Uniformly in the United States twenty years ago, death meant cessation of respiration and circulation. There was a transition period in which the legal meaning of death was uncertain. Liability waited around the corner for the unwary medical practitioner. Organ transplants extended lives, but the dead donors had to be kept artificially breathing. The emergence of brain death as an acceptable legal and medical definition and legislative action

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237 Id. at 57.
238 Id.
239 W. VA. CODE § 16-30-3(d) (1985).
240 W. VA. CODE § 16-30-9(g) (1985).
241 H. FIELDING, AMELIA, bk. iii, ch. 4, reprinted in THE OXFORD DICTIONARY OF QUOTATIONS
solved the medical practitioner's problem of potential liability in that respect, but it also signaled the beginning of new and previously unthought-of problems for individuals and the medical and legal professions in other respects.

Dying is still metamorphosing. Today, medical technology has pushed the boundaries of the possible beyond what most think is probable. One of the consequences has been a form of revulsion against what is possible. The prospect of the dying process being extended while a machine maintains bodily functions is no longer a future nightmare but a present possibility. The prospect of being a breathing body with no cognitive functions fed by a tube is a present possibility. The "right to die with dignity" movement is one of the reactions against these possibilities, and the natural death acts another.

It is probably rare now that a terminal patient's dying is extended beyond what the patient or the family wishes. There is an awareness of the possibilities for extending the dying process through medical technology and for shortening it by the exercise of individual rights. Problems with the person unfortunate enough to be in a persistent vegetative state are still being resolved. Withdrawing sustenance from him or her to allow death to occur is a developing solution, but it is a solution with problems of its own. A fine legal line is drawn between allowing natural death to occur by "stepping aside" and hastening or aiding death. The line is drawn with the knowledge that euthanasia hovers opposite "stepping aside," just across the line.

The concurring opinion by Associate Justice Compton in Bouvia addressed the "subtle distinction" drawn in frank terms. He believed that Bouvia preferred death and had an absolute right to that preference.

This state and the medical profession instead of frustrating her desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane.²⁴²

²⁴² Bouvia, 179 Cal. App. 3d at 1147, 225 Cal. Rptr. at 307.
Bouvia should have been able to "enlist assistance from others, including the medical profession, in making death as painless and quick as possible." This is a definite step over the line that society is not currently willing to take, but the possibilities of the present may pall before the possibilities of the future. The line drawn tomorrow may be in a different position, the distinction yet more subtle. The modern concept of dying has not yet stabilized, and a continuing metamorphosis can be expected.

Peggy L. Collins