PEPPERDINE UNIVERSITY

Pepperdine Law Review

Volume 13 | Issue 1 Article 5

12-15-1985

Balancing the Right to Die With Competing Interests: A Socio-Legal Enigma

Glenn W. Peterson

Balancing the Right to Die With Competing Interests: A Socio-Legal Enigma

I. INTRODUCTION

Today, few would dispute that the right to die exists, in one form or another, for those brazen or desperate enough to assert it in a court of law. Despite the obvious social and philosophical problems with such a shocking concept, the legal problems with the right to die have been related more to administration than to recognition. Most courts which have acknowledged the right to die (sometimes more palatably phrased as "the right to refuse medical treatment") have been more concerned with administrative problems than with recognition of the right itself.

The law of death and dying has clearly failed to keep pace with medical technology. Because of this gap between advances in medical treatments and advances in the law, physicians and families of dying patients are called upon to make disturbing personal decisions regarding the care of these patients without the benefit of clearly defined guidelines.

A. *The* Bartling *Case*

One of the most recent illustrations of judicial inability to administer a patient's right of privacy, which the court ironically found explicitly in the California Constitution and implicitly in the U.S. Constitution's fifth and ninth amendments,[1] is the case of *Bartling v. Superior Court (Glendale Adventist Medical Center).*[2]

1. Bartling v. Superior Court (Glendale Adventist Medical Center), 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984) (citing CAL. CONST. art. I, § 1 and Griswold v. Connecticut, 381 U.S. 479 (1965)).

2. 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984).

The decision came in a lawsuit first brought by William Francis Bartling, a 70-year-old man who died of lung disease on the eve of appeal after months of fighting to force doctors to disconnect his respirator. Citing lack of guidelines in state law for hospitals in so-called "right-to-die" cases, the California Second Appellate District agreed, just hours after Bartling's death, to hear arguments and rule as if his treatment were still at issue.[3] No California appellate court had ever articulated what rights a competent adult has to insist upon the discontinuation of life-sustaining medical treatment. With the court rendering an opinion despite Bartling's death, the situation was glibly labeled as "the only time in our nation's history that a competent, fatally ill patient [was] forced to survive beyond his death."[4] If Bartling were still alive, the court added in a footnote, its mandatory injunction would have read that he, "in the exercise of his right of privacy, may remain in defendant hospital or leave said hospital free of the mechanical respirator now attached to his body,"[5] and the hospital would be "restrained from interfering with Mr. Bartling's decision."[6]

This comment suggests that the crucial inquiry is to determine when the hospital or the state has the right to interfere with one's medical decisions. Incompetency would certainly be powerful justification for encroaching on free choice since, as a matter of social order, most people are not inclined to permit death and needless destruction as the products of insane decisions.[7] However, the *Bartling* court saw no contradiction in Mr. Bartling's desire to live and his preferring death to life on a respirator.[8] The unanimous court ruled that an occasional waver from this view "because of severe depression or for any other reason" did not justify the hospital's argument that he lacked a sufficient level of competence to make

---

3. Both sides in this case have urged us to address the merits of the petition and formulate guidelines which might prevent a reoccurrence of the tragedy which befell Mr. Bartling. We agree that in light of the important questions raised, this court should exercise its discretion to render an opinion in this case despite its mootness.

Id. at 189, 209 Cal. Rptr. at 221 (citation omitted).

4. The Restater (published by Western State University College of Law), Jan., 1985 at 7, col. 2.

5. 163 Cal. App. 3d at 197 n.8, 209 Cal. Rptr. at 226 n.8.

6. *Id.*

7. *See, e.g., Bartling*, 163 Cal. App. 3d at 196, 209 Cal. Rptr. at 226; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, 426 n.11 (1977) (the state has an interest in the prevention of irrational self-destruction).

8. 163 Cal. App. 3d at 193, 209 Cal. Rptr. at 223.

such a crucial decision.[9] Once it had determined Bartling's competence, the court stated that the major issue was whether the rights of the doctors and the state interest in preserving life outweighed the patient's rights.[10]

This comment will analyze the *Bartling* decision in the context of currently prevailing right-to-die law. Although there is some disparity in the lower court precedent recognizing that the constitutional right to privacy sometimes includes the right to refuse life-sustaining medical treatment, the United States Supreme Court has not yet tested such authority. Nevertheless, a consensus does emerge, of which *Bartling* is a compelling example.

II. THE COMPETING RIGHTS AND INTERESTS

The preservation of life, the need to protect innocent third parties, the prevention of suicide, and the maintenance of the ethics of the medical profession have been espoused as the chief interests which compete with the rights of patients to be removed from life-sustaining treatment.[11] These interests, compelling as they may seem, are not without major opposition from those who side with the patient. The right of a competent adult to refuse medical treatment has its origins in the constitutional right of privacy.[12] " 'In short, the law recognizes the individual interest in preserving "the inviolability of the person." ' "[13] Moreover, the right of privacy guarantees to the in-

9. *Id.* at 193, 209 Cal. Rptr. at 223-24.

10. *Id.* at 193, 209 Cal. Rptr. at 224.

11. *Id; see also Saikewicz,* 373 Mass. at 741-44, 370 N.E.2d at 425-27. These are generally regarded as the state's competing interests in right-to-die cases. It should be noted, however, that these interests are neither absolute nor exclusive; other interests have been delineated. *See, e.g.,* Commissioner of Correction v. Myers, 379 Mass. 255, 266, 399 N.E.2d 452, 458 (1979) (treatment deemed necessary to insure orderly prison administration); Eichner v. Dillon, 73 A.D.2d 431, 447, 452, 426 N.Y.S.2d 517, 531, 534 (1980), *modified sub nom. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981) (the state's economic interests are also a consideration when it intercedes to mandate life-sustaining treatment).

Assuming a sufficient justification exists, the state may also compel life-sustaining treatment for newborns, even if the family does not want state assistance. *See Medical Ethics: The Right to Survival, 1974: Hearings on Examination of the Medical and Ethical Problems Faced With the Agonizing Decision of Life and Death Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare,* 93d Cong., 2d Sess. 13 (1974) [hereinafter cited as *1974 Hearings*]; Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy,* 86 YALE L.J. 645, 657 (1977); *see also* Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis,* 59 TEX. L. REV. 1345 (1981); Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues,* 59 TEX. L. REV. 1401 (1981).

12. The *Bartling* court emphasized that this right is specifically guaranteed in the California Constitution and has been found to exist in the "penumbra" of rights guaranteed by the fifth and ninth amendments to the United States Constitution. 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225; *see also Griswold,* 381 U.S. at 484.

13. 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225 (quoting *Saikewicz,* 373 Mass. at 739, 370 N.E.2d at 424).

dividual the freedom to choose to reject, or refuse to consent to, intrusions of one's bodily integrity.[14]

A. The Preservation of Life

The most significant state interest is, of course, the preservation of life.[15] However, the *Bartling* court's assessment of the competing state interest in the preservation of life is not evident from the record. Neither a traditional balancing test nor any other similar analysis is present in the opinion. The court reiterated the significance of this competing interest, but it failed to address any notion of preserving Mr. Bartling's life.[16] Moreover, the court did not exhibit any apprehension in holding Mr. Bartling legally competent, despite the wavering in his decision due to severe depression or some other reason.[17] The court felt that his decision was not impaired "to the point of legal incompetency."[18]

The problem with the court's silence regarding the preservation of

---

14. *Id. See also Saikewicz*, 373 Mass. at 745, 370 N.E.2d at 427.

15. This was the prime contention of the hospital in *Bartling*. The doctors submitted a declaration that they were a "pro-life" hospital and that most of the staff would view disconnecting the life-support system as inconsistent with the healing orientation of physicians. 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225. The court, however, was quick to subordinate this contention, stating, "if 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 of the patient's hospital and doctors." *Id.*

16. The court merely stated that the patient's privacy right "must be paramount to the interests of the . . . hospital and doctors." *Id.* The court emphasized that the right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged; presumably, it cannot even be abridged by the medical profession. But is this equally true where the *state* wishes to abridge the exercise of this right? When is it necessary or proper for a court of law to abridge this constitutional right on behalf of the state? The only guideline indirectly suggested by the majority is competency. The court subliminally indicates that if there is no issue regarding the legal competence of the patient then there is no issue as to the legality of refusing treatment. 163 Cal. App. 3d at 193, 209 Cal. Rptr. at 223-24. This is, of course, a sensible social objective. One would hope there exists some societal reluctance to allow self-destruction where there is genuine doubt as to the patient's sanity or competency. Decisions which may reflect delusional thinking, psychotic depression, or some other condition of irrationality would hopefully be prevented. However, the court did little in the way of analyzing Mr. Bartling's competency; more would certainly be expected if competency or sanity is to be the fulcrum of judicial analysis in right-to-die cases. Admittedly, it would have been difficult for the *Bartling* court to challenge Mr. Bartling's competence because of his untimely death on the eve of appeal. For an in-depth treatment of right-to-die issues involving incompetent patients, see Comment, *In re Storar: The Right to Die and Incompetent Patients*, 43 U. PITT. L. REV. 1087 (1982).

17. 163 Cal. App. 3d at 193, 209 Cal. Rptr. at 224.

18. *Id.* Perhaps the court was quite correct in this regard. There is no fathomable reason why a 70-year-old man, suffering from five incurable illnesses, should be pre-

life issue is that no guidelines are provided for future courts called upon to make decisions in the next right-to-die case. What happens if the next patient who seeks to assert his or her rights is 24 years old and suffering from only one terminal disease instead of five? What if the patient prefers death to a painful life on a kidney machine installed in his home? Would the result be the same? Would he or she be summarily determined competent for the purposes of assessing the soundness of the decision? Such criticism of the *Bartling* analysis might otherwise be misplaced if not for the court's self-stated objective of establishing viable guidelines for future cases.[19]

If the court intended its decision to provide guidelines for future cases, these guidelines are sadly lacking. One could infer from the court's opinion that future cases should require a showing of incompetency based on evidence entirely independent of the patient's decision.[20] Aside from this inferred requirement of independent evidence establishing competence,[21] little can be gleaned from the *Bartling* decision as to how competing interests should be weighed. It is worth noting that the court did not acknowledge "a terminal condition" as being prerequisite to exercising one's right to refuse medical treatment.[22] *Bartling* actually establishes only that successful patients in future cases must be adults, must be legally competent (and are apparently presumed so absent an independent showing of incompetence), and must be incurably, although not necessarily terminally, ill. In all such cases, according to *Bartling,* the constitution-

---

sumed incompetent merely because he preferred death to an extremely painful life in a hospital.

19. The novel medical, legal and ethical issues presented in this case are no doubt capable of repetition and therefore should not be ignored by relying on the mootness doctrine. This requires us to set forth a framework in which both the medical and legal professions can deal with similar situations.

163 Cal. App. 3d at 189, 209 Cal. Rptr. at 221 (quoting Dority v. Superior Court, 145 Cal. App. 3d 273, 276, 193 Cal. Rptr. 288, 290 (1983)).

20. This would ensure that a patient is not presumed incompetent or insane because he merely seeks to exercise his right to refuse treatment.

21. The language of the majority suggesting a requirement of independent evidence of the patient's incompetency is exemplified by the following:

> Mr. Bartling knew he would die if the ventilator were disconnected but nevertheless preferred death to life sustained by mechanical means . . . . The fact that Mr. Bartling periodically wavered from this posture . . . does not justify the conclusion . . . that his capacity to make such a decision was impaired to the point of legal incompetency.

163 Cal. App. 3d at 193, 209 Cal. Rptr. at 223-24. This seems to imply that any showing of incompetency must be based on evidence independent of the decision to terminate treatment, or on evidence of the patient's lacking the capacity to appreciate the fact that removal will hasten his own death.

22. The court defined its task as one of determining "whether a competent adult patient, with serious illnesses which are probably incurable but have not been diagnosed as terminal," has the right to have life-support equipment removed, despite the fact that doing so will surely hasten his own death. 163 Cal. App. 3d at 189, 209 Cal. Rptr. at 221.

ally guaranteed right to refuse medical treatment "must not be abridged."[23]

B. Fear of Civil and Criminal Liability

Several doctors in the *Bartling* case expressed the view that disconnecting the ventilator would have been tantamount to aiding a suicide. The court, however, emphasized that Mr. Bartling's death would not have been brought about by unnatural means if the respirator were disconnected. "Rather, they would merely have hastened his inevitable death by natural causes."[24]

As to criminal liability, the *Bartling* court found the issue substantially answered in *Barber v. Superior Court*,[25] wherein the defendant physicians were charged with murder and conspiracy to commit murder.[26] Although the appellate court found the actions of the physicians to be intentional and done with the knowledge that the patient would die, the court found no criminal liability.[27] The *Bartling* court distinguished *Barber* on the grounds that the *Bartling* case was a civil action where the patient was not comatose, as was the patient in *Barber*. These distinctions notwithstanding, the court was "satisfied [that] the law as outlined is clear and if Mr. Bartling had lived real parties could not have been criminally or civilly liable for carrying out his instructions."[28]

---

23. *Id.* at 195, 209 Cal. Rptr. at 225.

24. *Id.* at 196, 209 Cal. Rptr. at 225. The court again favored quotation over analysis:

> The interest in protecting against suicide seems to require little if any discussion. In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. . . . Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

Id. at 196, 209 Cal. Rptr. at 226 (quoting *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11).

25. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

26. *Id.* at 1010, 195 Cal. Rptr. at 486.

27. *Id.* at 1022, 195 Cal. Rptr. at 493.

28. 163 Cal. App. 3d. at 197, 209 Cal. Rptr. at 226. The court added:

> Furthermore, in future similar situations, parties facing the problems confronting real parties here should be free to act according to the patient's instruction without fear of liability and without advance court approval. In accord with our conclusion is the *Barber* court's statement that ". . . in the

C. *Maintaining Medical Ethics*

The *Bartling* court made it clear that the preservation of medical ethics, while a laudable consideration, is patently subordinate to the privacy interests of the patient. The court expressed its confidence in the moral and ethical beliefs of Glendale Adventist Hospital and the position it had taken in this case.[29] However, the court emphasized that the right of the patient to determine his own medical treatment must be paramount to the interests of the medical profession, if that right is to have any meaning at all.[30]

D. *Protection of Innocent Third Parties*

Although not discussed in the *Bartling* case,[31] the protection of innocent third parties as a state interest has been invoked, for example, where the patient attempting to refuse treatment has minor children who would be left without a parent should the cessation of treatment result in the patient's death.[32] In addition to the protection of minor children, the state has a clear interest in seeing that persons honor their obligation to support and care for their dependents. Otherwise, the state itself would have to provide for these dependents.

III. PRACTICAL PROBLEMS WITH *BARTLING* AS A GUIDELINE

The problems with the *Bartling* standard for "pulling the plug" are largely self-evident. Among these are concerns arising from the lack of certainty in the case of a patient who vacillates in his decision. Furthermore, attribution problems arise when a patient wishes to be removed from life-support because of "severe depression" or other similar reasons.[33] Which decision does the hospital honor when the

---

absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made."

Id. (quoting *Barber*, 147 Cal. App. 3d at 1021, 195 Cal. Rptr. at 493).

29. 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225.

30. *Id.* Courts do not view the interest of maintenance of the ethical integrity of the medical profession as a strong state interest. *See, e.g., Myers*, 379 Mass. at 265, 399 N.E.2d at 458. The interest is relevant, however, when medical personnel seek to administer treatment and the patient or his guardians will not consent. Under the guise of protecting the ethical integrity of physicians, the state has a pretext by which to intervene so that health professionals will not be forced to allow a person to die whom they feel duty-bound to save.

31. 163 Cal. App. 3d at 195 n.6, 209 Cal. Rptr. at 225 n.6.

32. *Id.* The leading case in this area is *In re* President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964), in which the court ordered blood transfusions over the patient's religious objections where she had to care for a seven-month-old child. *See also* United States v. George, 239 F. Supp. 752 (D. Conn. 1965) (39-year-old father of four objected to blood transfusions on religious grounds).

33. Is it conscionable to accept the patient's decision to perish when the basis for that decision is attributable to depression, shock, or some other debilitated state? The

patient decides one day to be removed and the next day to continue treatment? Is this type of vacillation distinguishable from that in which a patient manifests no change of decision until he is nearly asphyxiated from being without oxygen for three and a half minutes?[34]

A. When is Self-Destruction Rational?

The *Bartling* court confirmed that one of the state interests in competition with the patient's right to be removed from life-sustaining medical treatment is the "prevention of irrational self-destruction."[35] The question which naturally arises is whether a proper inquiry can be made into the rationality of the patient's decision without specific guidelines designed for that purpose. A further question arises as to who will make this determination.[36]

Bartling court evidenced a conspicious disregard for the inherent problems of such a decision. On the one hand, the court ratified the state interest in the "prevention of irrational self-destruction," *see supra* note 24; yet, on the other hand, it was not concerned with the fact that Mr. Bartling wavered in his decision "because of severe depression or for any other reason." 163 Cal. App. 3d at 193, 209 Cal. Rptr. at 224. The fact that Mr. Bartling had a history of "chronic acute anxiety/depression" and alcoholism did not concern the court either. *See id.* at 189-90, 209 Cal. Rptr. at 221.

34. Although they did not challenge his legal competency, the doctors and Glendale Adventist contested Mr. Bartling's ability to make a meaningful decision because of his vacillation. *Id.* at 192, 209 Cal. Rptr. at 223. The challenge was based on the declarations of several nurses who related instances in which the ventilator tube accidentally detached and Mr. Bartling signalled frantically for them to reconnect it. Mr. Bartling had also made several statements to his doctors and nurses in which he indicated that "he wanted to live and did not want the ventilator disconnected." *Id.* The question which arises is whether such conduct amounts to vacillation at all. Could not such a reaction be more properly attributed to involuntary reflex mechanisms than to vacillation? Must one go out with a smile on his face to sufficiently manifest the certainty of his intentions? Instead of choking to death, must one peacefully asphyxiate to be sure that his life and death decision will remain uncontested? The *Bartling* court again avoided touching on a difficult question by declining to confront the practical problems presented and by failing to address its implications in future cases. Instead, the court likened the alleged vacillation of Mr. Bartling to that of an amputation patient in Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978). The court dismissed the vacillation issue with a brief quotation from *Lane,* stating, "the fact that [the patient] has vacillated in her resolve not to submit to the operation does not justify a conclusion that her capacity to make the decision is impaired to the point of legal incompetence." 163 Cal. App. 3d at 192 n.3, 209 Cal. Rptr. at 223 n.3 (quoting *Lane,* 6 Mass. App. Ct. at 384, 376 N.E.2d at 1236).

35. *See supra* note 24.

36. One of the apparent objectives of the *Bartling* court was to keep such determinations out of the courts. 163 Cal. App. 3d at 197, 209 Cal. Rptr. at 226. Who, then, is left to determine the rationality of such decisions? Such power cannot be given to doctors or hospitals without creating inherent conflicts of interest, especially where it is the medical professionals who usually oppose the removal in the first place. Regardless, the *Bartling* court made it clear that the patient's rights are flatly superior to the interests of the medical profession. *Id.* at 195, 209 Cal. Rptr. at 225.

No one appears more appropriate to decide the rationality of the patient's decision than the courts. However, even on a case-by-case basis, a court of law may justifiably find itself hampered in deciding the rationality of such a decision without appropriate guidelines.[37] Guidelines might also be necessary to ensure uniformity among such decisions. Without a yardstick for assessing the soundness of patients' and guardians' decisions, essentially similar cases might wrongly produce different results.[38]

There should be no mistake that the determination of a patient's right to die under present law is purely a judgment call.[39] What may seem irrational to the doctors may seem eminently reasonable to the legally competent but suffering patient. Moreover, what may seem rational for a 70-year-old man expected to live for another year may, under otherwise identical circumstances, seem virtually misanthropic for an 18-year-old boy.[40] It is indeed difficult to consider the rationality of the decision from any point of view but the patient's; after all, it will be the patient who is most affected by the ruling. A ruling in favor of continuing treatment against the patient's will is especially

---

37. *See Barber*, 147 Cal. App. 3d at 1014, 195 Cal. Rptr. at 488.

38. *See, e.g., Is There a Right to Die — Quickly?*, 80 J. PEDIATRICS 904, 905 (1972) (two differing opinions regarding treatment of children with meningomyeloceles); Ellis, *Letting Defective Babies Die: Who Decides?*, 7 AM. J.L. & MED. 393 (1982) (legislature should set guidelines for parents and physicians to ensure that decisions will be consistent, predictable, adequately informed, and in accord with community values).

39. Current case and statutory law does establish a right to die in certain instances. The procedures used to implement this right are so confusing, however, that it cannot be asserted effectively. It is possible for the courts to create law in this area, but "[b]ecause the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding." Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980). Indeed, at present, only 11 states have codified a statutory right to die. Those states are: Alabama, ALA. CODE §§ 22-8A-1 to -10 (1984); Arkansas, ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1983); California, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985); Idaho, IDAHO CODE §§ 39-4501 to -4508 (Supp. 1983); Kansas, KAN. STAT. ANN. §§ 65-28,101 to -28,108 (Supp. 1983); Nevada, NEV. REV. STAT. §§ 449.550-.690 (1983); New Mexico, N.M. STAT. ANN. §§ 24-7-1 to -7-11 (1981); North Carolina, N.C. GEN. STAT. §§ 90-320 to -323 (Supp. 1983); Oregon, OR. REV. STAT. §§ 97.050-.090 (1983); Texas, TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1985); Washington, WASH. REV. CODE §§ 70.122.010-.122.905 (Supp. 1985).

Even with statutory guidelines, the *Bartling* court noted the procedural requirements of the California Natural Death Act were "so cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desires." 163 Cal. App. 3d at 194 n.5, 209 Cal. Rptr. at 224 n.5 (quoting *Barber*, 147 Cal. App. 3d at 1015, 195 Cal. Rptr. at 489).

40. In a landmark case, the court observed that doctors distinguished "between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable." *In re* Quinlan, 70 N.J. 10, 47, 355 A.2d 647, 667, *cert. denied*, 429 U.S. 922 (1976). *See also Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 425-26 (state interest declines where the patient's life is merely prolonged and not preserved).

troublesome where the treatment is physically painful or the patient never adjusts to his condition psychologically.[41] The more miserable the patient's life, the more inherently rational his decision would seem.

Should this then be our standard for determining rationality — the miserableness of the patient's condition? If so, it begs the question. It is most unlikely that a patient would ever assert his right to die on his own behalf without being somewhat miserable. It is indeed difficult, if not impossible, to determine when it is or is not rational for a patient to choose death over life. But it is no less difficult to compel a suffering patient to live against his will, especially where the treatment compelled is painful and intrusive.[42]

B. When, If Ever, Is There No Hope of Cure or Preservation?

In further examining the rationality and competency of a decision to refuse treatment, the *Bartling* court adopted the contention that a proper decision might be rationally made where "death is inevitable"[43] and there is "no hope of cure or preservation of life."[44] These standards are completely useless as guidelines. When could it ever be sensibly argued that death is *not* inevitable, or that there is absolutely no hope of cure or preservation of life? If a patient is expected to live for more than one year, there is always a justifiable hope of developing a cure, or at least a more effective treatment. Moreover, if there is not at least some medical capability of preserving the patient's life, the patient has little to contest.[45]

C. When Does the State Have a Meaningful or Effective Interest?

Under the *Bartling* standard, could there ever be a case where the state interest in preserving life would prevail over the patient's right to refuse treatment? The *Bartling* court made it clear that the state

41. If the life sought to be continued by the compelled treatment will be brief, painful, or extended only by a great degree of bodily intrusion, the state's interest is minimized. Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App.), *aff'd*, 379 So. 2d 359 (Fla. 1980). *See also* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

42. *See supra* note 41.

43. 163 Cal. App. 3d at 196, 209 Cal. Rptr. at 226 (quoting *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11).

44. *Id.*

45. Obviously, if medical technology could do nothing to preserve the patient's life, he would either already be dead or have nothing from which to seek removal.

interests in preventing suicide and maintaining the ethical integrity of the medical profession were of little concern when in competition with individual rights.[46] The court declared the most significant state interest to be that of preserving life.[47] It did not suggest, however, any circumstances under which this interest might have effect in the presence of contrary desires on the part of the patient. All the court ventured to say on the matter was that, "[b]alanced against [the patient's] rights are the interests of the state in the preservation of life . . . ."[48] The court declined to say how such rights would be balanced, or what circumstances, if any, would tip the scale in favor of the state.

The court's failure to address these issues raises practical problems for physicians and attorneys who might rely on *Bartling* as a guideline in the practice of their profession.[49] What are the physician's liabilities where he terminates medical treatment at the patient's behest and only later discovers that the state interest in preserving life was inappropriately violated?[50] If the state is to have an interest in the continuing life of a patient, it is necessary to determine the state interest and when it comes into effect. It must be made cognizable, articulable and palpable if it is to have a place in the decision-making process. Guidelines are of obvious importance to medical and legal practioners. The *metes and bounds* of the competing state interest are even more important to the suffering patient because the patient cannot readily contest an undefined state interest.

D. The Bartling *Decision is of Little Help in Future Cases*

Even where future cases are identical in the legal sense, *Bartling* offers little or no guidance where the facts are dissimilar. The decision leaves an uncertainty concerning the definition and effect of the competing state interests, and the rationality of the patient's decision to end life support defies anything more than circular and inconsis-

---

46. *See supra* notes 24 and 30 and accompanying text.

47. 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225.

48. *Id.*

49. One of the intentions of the *Bartling* court was to ensure that parties in future cases would be free to act in accordance with the patient's instructions without prior court approval. *See supra* note 28. There is an obvious practical danger created by acting upon the patient's instructions where a contrary, but as yet undetermined, state interest exists in keeping the patient alive.

50. The obvious answer would seem to be criminal liability, although probably not for murder. *See generally* Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (attending physicians who ordered removal cannot be charged with murder). In a comparable situation charges were reported dropped against a White Plains, New York woman who was indicted for performing an abortion on herself during her ninth month of pregnancy. 49 Weekly Law Digest, Feb. 22, 1985, at 8e, col. 2. "This case was said to be 'the first of its kind in New York and possibly the nation.' " *Id.*

tent analysis. Right-to-die cases in the wake of *Bartling* will therefore be hampered with doubt regarding its applicability. Any patient who is a competent adult and suffering from a serious and probably incurable illness should arguably be afforded the same preference in balancing the competing interests as Mr. Bartling. Further, problems may arise in determining the rationality of the patient's decision where the patient is expected to live for more than one year under continued treatment.[51] Similar problems may also arise in determining whether the patient's illness is sufficiently serious and incurable to justify termination of medical treatment, especially if the treatment sought to be enjoined is relatively less painful and less intrusive than that in *Bartling*.[52] The *Bartling* decision offers sufficient guidelines only where the parties are certain that it applies to their case. Therein lies the problem.

IV. PROPOSAL FOR GUIDELINES: A BALANCING EQUATION

At the outset, it should be stated that the following equations cannot balance the competing interests in right-to-die cases with mathematical certainty and precision. There are cases where the interests of the respective parties may differ by merely fractions of a point. This is not intended to suggest that the processes discussed are sterile and mathematically objective, free from subjectivity and human compassion. Rather, the proposed equations seek merely to take into account all interests which have been deemed relevant to the inquiry and, in some cases, additional interests which should be considered relevant. Attempts are made to assign the respective interests appropriate values while allowing, at the same time, for changes in these values since the circumstances under consideration are subject to change.

The hypotheses herein are also somewhat subjective. However, where subjectivity is expressed, an attempt is made to ensure that it be uniform and sensible. Moreover, subjectivity plays a role only in assessing the categorical degree of certain interests as low, medium, or high in importance, and is never used to discount the competing

51. As a patient's life expectancy increases, the rationality of the decision to terminate life-support arguably becomes more questionable. *See infra* notes 67-70 and accompanying text.

52. Where the painfulness and intrusiveness of the treatment decreases, the state's interest in preserving life increases. At some point, if the state has a genuine and nonfictional interest, it must eventually outweigh those of the patient. *See infra* note 66 and accompanying text.

interests involved. The equation as set forth requires values for all competing interests, and is designed to be as fair as possible after accounting for all such interests.

A. The Basic Equation

On the left side of the equation are the variables which reflect the interests of the state: namely, the state interest in the preservation of life[53] and the inverse of the degree of intrusion[54] which the compelled treatment requires. The right side of the equation sets forth the considerations which are more properly attributed to the interests of the patient.[55] Schematically, the equation is organized as follows:

(state concerns) $\Leftrightarrow$ (patient's concerns)
<balanced against>

More specifically, the left side, representing state concerns, looks like this:

(state interest) $\times$ (1/intrusion) $\Leftrightarrow$

The first variable denotes the interest of the state in the preservation of life. This has been determined to be the most significant competing interest in right-to-die cases.[56] The value of this variable is rated on a scale of 1 to 3 (1 = low, 2 = medium, and 3 = maximum). In most instances the state interest in the preservation of life will be the maximum value of 3.[57] For the purposes of analyzing the competing interests in right-to-die cases, it is usually prudent and proper to

---

53. For a discussion of the state interest in preserving life and its common law origins, *see supra* notes 15-23 and accompanying text.

54. "[T]he individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." *Quinlan*, 70 N.J. at 41, 355 A.2d at 664. In one case involving a request for an order directing amputation of both legs, the court held "the extensive bodily invasion involved . . . is sufficient to make the State's interest in the preservation of life give way to [the patient's] right of privacy . . . regardless of the absence of a dim prognosis." *In re* Quackenbush, 156 N.J. Super. 282, 290, 383 A.2d 785, 789 (Morris County Ct. 1978).

55. "In deciding cases in which a patient's right to die has been asserted, the courts have almost universally balanced the individual's right to die or to terminate treatment against the various interests of the state." Comment, *Law at the Edge of Life: Issues of Death and Dying*, 7 HAMLINE L. REV. 433, 437 (1984).

56. *See supra* note 15 and accompanying text. *See also* Nesbitt, *Terminating Life Support for Mentally Retarded, Critically Ill Patients*, 3 J. LEGAL MED. 245 (1982). "Western society has traditionally placed a nearly absolute value on human life. The Biblical injunction against the taking of life is reflected in the early common law, and embodied in the penal code of every state of the Union." *Id.* at 248 (footnotes omitted).

57. The interest is not, however, absolute. If the life to be preserved is expected to be long and healthy after treatment, the state's interest is quite compelling. *See, e.g.*, John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971). However, if the life to be continued under compelled treatment is expected to be brief, painful, or extended only by a great degree of bodily intrusion, the state's interest will be minimal at best. *See supra* note 41.

Because the equation accounts for these countervailing interests of the patient on an individual basis, it is appropriate to begin with the assumption that a maximum state

always assume maximum state interest.[58]

The second variable affecting the weight of state concerns is the *inverse* of the degree of intrusion required by the life-sustaining treatment. This variable is also valued on a scale of 1 to 3, designating low, medium and high levels of intrusion, respectively.[59] The greater the intrusion, the lower the value of this variable. Notice that as the degree of intrusion in treatment increases to the maximum, the value of the total state concerns approaches 1. The following denotes *maximum* state interest in preserving life and *minimum* intrusion in the continued treatment:

(state interest in preserving life) × (1/intrusion) ⇔
(3) × (1/1) = 3 ⇔

The right side of the equation contains the variables which are more properly attributed to the patient. These variables are as follows: 1) the patient's desire to be removed from life support equipment;[60] 2) the *inverse* of the number of years which the patient is expected to live;[61] 3) the degree of medical certainty that the patient's condition and prognosis has been accurately diagnosed (where 1.0 equals absolute certainty);[62] and 4) the degree of pain and suffering to which the patient is subjected if the treatment continues unchecked.[63] Schematically, the right side of the equation looks like

---

interest exists in order to avoid factoring the same interests twice—once on the state's side of the equation and once on the patient's side.

58. It has been deemed desirable, in close cases, to commit errors "on the side of life." *In re* President and Directors of Georgetown College, 331 F.2d 1000, 1010 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

59. *See supra* note 54.

60. This value is maximum, or 3, where the patient is legally competent and has not wavered in his or her decision. Fear of irrationality in the decision or uncertainty as to its soundness is minimized by the absence of vacillation. A maximum desire can also be realized where there is certainty as to the patient's preferences, such as when the patient is conscious and competent to assert his or her own rights. Adjustments may be required to reflect "substituted judgment" cases, *see infra* note 158, or those cases involving infants or unconscious patients in need of life-saving treatment. *See infra* notes 165-94 and accompanying text.

61. The inverse of this expectancy is utilized because the right to terminate life is apt to be recognized where the treatment will merely prolong life rather than preserve it, especially when the life to be prolonged will be of brief duration. *Quinlan*, 70 N.J. at 23-29, 355 A.2d at 655-57; *Saikewicz*, 373 Mass. at 737-40, 370 N.E.2d at 423-24; *Eichner*, 73 A.D.2d at 468-69, 426 N.Y.S.2d at 545; *cf.* Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982) (involving an infant). Of course, the right to refuse life-sustaining medical treatment is not an issue where the state recognizes the concept of brain death. If the patient were brain dead, the number of years of life expectancy would be zero. *See, e.g.*, Lovato v. District Court, 198 Colo. 419, 601 P.2d 1072 (1979) (en banc).

62. *See infra* notes 75-80 and accompanying text.

63. This variable is also rated on a scale of 3, 3 being maximum and 1 being mini-

this:

⇔	(patient's desire to be removed)	×	(1/yrs. expected to live)	×	(degree of medical certainty)	×	(pain & suffering)

B. Hypothetical No. 1

A hypothetical application best illustrates how the equation works. Assuming maximum state interest in preserving the hypothetical patient's life and that the treatment's intrusion is minimal, the left side of the equation (state side) will look like this:

(state interest in preserving life)	×	(1/intrusion)	⇔
(3)	×	(1/1) = 3	⇔

If the hypothetical patient is legally competent and his desire to be removed from the life-sustaining treatment is maximum,[64] he is expected to live for one year with 80% medical certainty, and if his pain and suffering are minimal,[65] the right side of the equation will look like this:

⇔	(patient's desire to be removed)	×	(1/yrs. expected to live)	×	(degree of medical certainty)	×	(pain & suffering)
or:	(3)	×	(1/1)	×	(.80)	×	(1) = 2.4

The entire equation reads:

(3) × (1) = 3 ⇔ (3) × (1/1) × (.80) × (1) = 2.4
3 ⇔ 2.4

RESULT: State interest prevails.

This is logical if the interest of the state in preserving life is to have any meaning. Where there is minimal state interest, minimal intrusion and minimal pain and suffering for the patient, the state's interest should prevail under these circumstances.[66]

---

mum. The *Quinlan* court recognized a patient's interest in self-determination in the face of, *inter alia*, a painful and certain death. 70 N.J. at 43, 355 A.2d at 665. The death of patients in this context has raised fear among those who oppose euthanasia. Such fear has been said to be based upon the possible expansion of euthanasia practice beyond that which is legally conscionable. For example, initial euthanasia legislation could allow a procedure by which a qualifying patient could request medication that would cause a swift and painless death. Those who fear euthanasia feel that once the public has adjusted to this type of extermination, it would then be easier to enact less restrictive laws that could ultimately lead to the involuntary and active euthanasia of persons who have become less productive members of society. Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation,* 42 MINN. L. REV. 969, 976 (1958).

64. This is because he is conscious and able to assert his right to die on his own behalf. *See supra* note 60 and accompanying text.

65. The pain and suffering variable is therefore designated as 1.

66. Where no "heavy physical and emotional burdens" would be imposed, the state interest in the preservation of life applies with full force. *Saikewicz,* 373 Mass. at 744, 370 N.E.2d at 427.

C. Hypothetical No. 2 — Low Life Expectancy

Where the patient's condition has been diagnosed as terminal, it is fairly well-settled that the right to refuse treatment is at its height.[67] But even where there has been no diagnosis of terminal condition, as in the *Bartling* case, the state's comparative interest declines along with the patient's life expectancy. How short must one's life expectancy be before a condition is affirmatively diagnosed as terminal? If the patient is expected to live only two days, there is little doubt that the condition is terminal in both the legal and medical sense. But how should a court treat a case where the patient is *almost* terminal? Suppose the patient is expected to live for ten months. This period of time is short enough to justify a diagnosis of terminal condition, yet long enough to argue otherwise.[68]

If the foregoing equation is used to balance the interests, a court would not need to address the difficult question of how short one's life expectancy must be in order for the condition to be considered terminal. The equation would instead weigh the interests without drawing a static line as to what constitutes a condition "terminal" enough to award preference to the patient's rights. Plugging the variables into the equation and keeping all facts the same, except the life expectancy, which becomes nine months instead of one year, analysis of a second hypothetical patient with a lower life expectancy leads to different results:

State Concerns				Patient's Concerns				
(3) × (1/1)	=	3	⇔	(3) × (1/(9/12))	×	(.80) × (1)		
				(3) × (12/9)	×	(.80) × (1)	=	3.2
		3	⇔	3.2				

RESULT: Patient's concerns prevail.[69]

---

67. For example, the California Natural Death Act provides in pertinent part: "The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition." CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1985). *See also Bartling*, 163 Cal. App. 3d at 194 n.5, 209 Cal. Rptr. at 224 n.5. For a listing of similar statutes in other jurisdictions, see *supra* note 39.

68. "By parity of reasoning, the constitutional right to privacy, we believe, encompasses the freedom of the terminally ill but competent individual to choose for himself whether or not to decline medical treatment where he reasonably believes that such treatment will only prolong his suffering needlessly. . . ." Eichner v. Dillon, 73 A.D.2d 431, 458-59, 426 N.Y.S.2d 517, 539 (1980), *modified sub nom. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). *See also infra* notes 165-94 involving infant and newborn patients.

69. Because the equation utilizes the number of years, a nine-month life expec-

The formula thus allows for consideration of a condition approaching the status of "terminal" without drawing a bright line in the chronological sense. The closer the life expectancy is to zero, the more the condition becomes "terminal" and the patient's interests properly become more influential.[70] In one instance, a patient might be considered duly terminal where she is expected to live for nine months and the other variables are weighty. For example, assume her treatment is intrusive and painful, and she has a maximum desire to be removed from life support in order that she might die in a more dignified environment.[71] In another case, however, the patient may require a more "terminal" condition (for example, say a life expectancy of five months) because his treatment is less painful and less intrusive,[72] and his desire to be removed is less than maximum because he has wavered in his decision.[73] In such a case, the patient's condition would have to be more grave in order to overcome the competing state interest in preserving life.[74]

D. The "Medical Certainty" Factor

In carefully examining the foregoing equation, questions no doubt arise as to the necessity of the "medical certainty" factor.[75] Moreover, it may be contended that the medical certainty factor is misplaced in the present equation.[76] In answering these questions, the

---

tancy is designated with the fractional equivalent, 9/12. Thus, the inverse becomes "1/(9/12)" or "12/9."

70. The more terminal the patient's condition, the more futile the life-sustaining treatment becomes. Thus, the more futile the treatment, the more obvious it is that "such treatment will only prolong his suffering needlessly. . . ." *Eichner*, 73 A.D.2d at 458-59, 426 N.Y.S.2d at 539.

71. *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 15-11, at 935 (1978). Tribe defines a dignified environment as one more empathetic: something other than "the demeaning tangle of technology that has become death's least human face. . . ." *Id.*

72. Examples of less intrusive treatment usually include those which require less physical encroachment, such as blood transfusions and narcotic drugs. It should be noted, however, that bodily intrusion has been deemed significant though no direct physical contact may be involved in the application of the treatment. *See, e.g., Saikewicz*, 373 Mass. at 732-35, 370 N.E.2d at 420-22 (chemotherapy treatment).

73. *See infra* notes 159-62 and accompanying text.

74. Because of the lowered value of the other patient factors, the patient's life expectancy must be less in order to offset the reduction in value of his total concerns.

75. To reduce the possibility of judgmental error or even personal bias, a second attending physician's concurrence with the nature of the illness and the prognosis should be required. The accuracy of diagnosis and prognosis is crucial to such a decision. *Cf. In re* Quinlan, 70 N.J. 10, 51, 355 A.2d 647, 669, *cert. denied*, 429 U.S. 922 (1976) (prognosis is focal point in decision to remove life support). Even if the prognosis is unclear or uncertain, the obscurity of prognosis is nevertheless an important factor for the patient, as well as others, to consider.

76. For example, some may argue that the medical certainty factor belongs on the side with the state's interests, because the more certain the patient's prognosis and treatability, the more concrete the state interest in preserving the patient's life. It should be noted, however, that the medical certainty factor, although placed on the pa-

medical certainty variable is factored as it is to discount the gravity of the patient's interests in cases of uncertain prognosis or treatability.[77]

Where the status of the patient is uncertain in the medical sense, it is logical to offset the patient's interest in terminating medical treatment with the hope (or at least the consideration) of developing a cure or a more effective treatment program.[78] This factor allows for unforeseen and sudden progress in medical science.[79] It would indeed be retrospectively irrational to have allowed self-destruction where a cure or progressive treatment is developed soon after the patient's self-directed death. Furthermore, a stronger medical certainty as to the patient's condition and prognosis should rightly strengthen her case for removal from life support.[80] The equation affords medical certainty this effect by factoring it into the analysis. The following hypothetical illustrates this effect.

E. Hypothetical No. 3 — Medical Uncertainty in a Younger Patient

Assume in this case that the patient is about 30 years old and is expected to live a minimum of six years. He is, however, suffering from a form of AIDS[81] of which little is known, thereby making medical

---

tient's side, favors the state in cases of uncertainty by mathematically lowering the patient's total concerns.

77. The equation favors, to a limited extent, life in this instance, despite authority which has suggested that *uncertainty* favors the patient. The patient should be free of "heavy physical and emotional burdens" which would impose "a brief and *uncertain* delay in the natural processes of death." Commissioner of Correction v. Myers, 379 Mass. 255, 263, 399 N.E.2d 452, 456 (1979) (emphasis added) (quoting *Saikewicz*, 373 Mass. at 744, 370 N.E.2d at 427).

78. A more effective treatment plan might involve, for example, less intrusion and pain or even permit treatment on an out-patient basis. It should not be overlooked that a cure or improved treatment may be developed during the time within which the patient is expected to live. Morris, *Compelling A Competent Adult to Submit to Medical Treatment: An Argument Against Antidysthanasia*, 16 FORUM 911, 919 (1981).

79. Familiar examples include the recent progress in detecting and treating AIDS, *see infra* note 81, and the increasingly routine implantation of artificial hearts.

80. For example, a prognosis may be certain but "dim". *See Quinlan*, 70 N.J. at 43, 355 A.2d at 665.

81. The Center for Disease Control defines a case of AIDS as "a reliably diagnosed disease that is at least moderately indicative of an underlying cellular immunodeficiency in a person who has had no known underlying cause of cellular immunodeficiency nor any other cause of reduced resistance reported to be associated with that disease." *Acquired Immune Deficiency Syndrome (AIDS) Update — United States*, 32 CENTERS FOR DISEASE CONTROL: MORBIDITY AND MORTALITY WEEKLY REP. 309, 309-10 (1983). *See generally* Comment, *AIDS: A Legal Epidemic?*, 17 AKRON L. REV. 717 (1984) (dealing exclusively with the disease and its impact on the legal profession).

certainty of his prognosis and treatability a low 60%. Assume further that his desire to be removed from life support is maximum because of the intense pain and suffering caused by his affliction. The degree of intrusion required for his continued treatment is maximum because of the severity of his condition.[82] He suffers from acute pain and discomfort and wishes to be removed immediately to allow the processes of nature to take their course; he states that he would rather die naturally than live an extremely painful and uncertain life in the hospital. In these circumstances, what would be the result? Would the state have the power to compel his continued treatment and subject him to a painful and uncertain existence? Plugging the foregoing values into the formula produces the following results:

State Concerns			Patient's Concerns	
$(3) \times (1/3) =$	1	$\Leftrightarrow$	$(3) \times (1/6) \times (.60) \times (3) =$	$.9$
	1	$\Leftrightarrow$	$.9$	

RESULT: State concerns prevail.

Under the foregoing analysis the state seems to indeed have the power, in the form of prevailing interests, to compel this unfortunate patient to continue treatment and live, in essence, a life of pain and agony against his will. This speaks rather poorly of the equation's viability in handling such cases, since it does not seem conscionable to subject a competent adult patient to such wretchedness. This result may not differ markedly from others reached under present law.[83]

Such congruity notwithstanding, the instant results should be considered unacceptable. Aside from the legal and constitutional questions, it seems inherently wrong to subject a competent human being to a prolonged and painful existence against his will merely because it is medically possible to cure the terminal condition and because the state has some inarticulable interest in preserving life. A more palatable approach would hopefully give more consideration to the comfort and well-being of the individual patient.[84] For this reason, the foregoing equation is in need of another variable to account for such situations. This variable is designed to provide more consideration to

---

82. The degree of intrusion therefore is assigned a value of 3. Indeed, it has been argued that nontreatment may be "good medical practice." Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213, 214 (1975).

83. For one commentator's model favoring treatment under analogous circumstances, see Morris, *supra* note 78, at 919-20.

> For this patient, death is inevitable but not imminent. He is not confronted with an emergency situation where a decision must be made immediately as to whether he is to live or die. With no treatment he may live twelve more months; with it his life may be prolonged as much as five years.

Id. at 919. Thus, in this instance, Morris suggests that a court compel treatment through an appointed guardian. *Id.* at 920.

84. "[T]he prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment." *Saikewicz*, 373 Mass. at 743, 370 N.E.2d at 426.

the patient where his existence is painful, uncertain, and significantly impaired.

F. The Life Quality Factor

The needs of patients who find themselves in these unfortunate circumstances are addressed by the introduction of a factor which denotes a change in the quality of the patient's life.[85] This factor is to be rated on a scale of one to zero and is dropped from the analysis completely where the value is zero in order to preserve the mathematical integrity of the multiplicative equation.[86] Such a factor might initially seem too subjective and pro-patient to have any meaning in an equation which purports to objectively weigh the interests of all concerned. However, one must keep in mind that such a factor represents only one small part of the patient's concerns and constitutes only one of many variables in the equation. Viewed in this light, such a factor should appropriately serve its purpose without sacrificing any analytical integrity in the long-run.

A "quality of life" factor necessarily requires a determination as to how the patient has been affected by his infirmity. Even though such determinations may at times require philosophical inquiries, they should not be shunned on that basis. The law should indeed be concerned with how the patient has been affected in these cases. If no consideration is given to the patient's life quality for fear of philosophical inquiries, we do suffering patients a great injustice.[87] Moreover, fear of life quality assessments may often be "knee-jerk" reactions to the mere idea of deciding these issues using life quality as a yardstick. As a humane society, we have been prone to protect and preserve life regardless of its quality as a matter of government

85. For a discussion of the interest of the patient in the quality of life, see Dubos, *The State of Health and the Quality of Life,* 125 W.J. MED. 8 (1976):

> [M]edicine cannot by itself determine the quality of life. It can only help people to achieve the state of health that enables them to cultivate the art of life—but in their own way. This implies the ability to enjoy the fundamental satisfactions of the biological *joie de vivre.* It implies also the ability for each person to do what he wants to do and become what he wants to become, according to human values that transcend medical judgment.

Id. at 9. At least one court has stated, "account is to be taken of the prognosis and of the magnitude of the proposed invasion." *In re* Spring, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980). *See also Saikewicz,* 373 Mass. at 735, 754, 370 N.E.2d at 422, 432.

86. It is inconceivable that the patient's interests, under any circumstances, would amount to zero.

87. *See supra* note 84 and accompanying text.

policy.[88] This is, of course, proper from the state's point of view. It would certainly consummate many an Orwellian fear should the government begin dabbling in these and other life-support decisions from a standpoint of quality assessment.[89]

The quality of life is, of course, in the eyes of the beholder.[90] The quality factor contained in the equation merely accounts for objective and rational[91] reductions from the point of view of the beholder (the patient) with sufficient safeguards to avoid irrational or improperly attributed decision-making.[92] The equation neither permits nor requires the state to indulge in quality inquiries, nor does it require the patient to do so where such analysis is irrelevant or defies calculation.[93] This factor simply attempts to compensate for those situations where the overriding state interests would otherwise compel a patient to live a painful and vexatious life. The patient's existence should not be compelled by the state without some showing that the life sustained will be a worthwhile one. It would seem otherwise unjust to compel continued and involuntary suffering without some evidence that the life being artificially and forcefully preserved is meaningful enough to justify the invasion of privacy.

The salient question arises, then, as to what analysis may be used to determine a change in the quality of one's life. Some suggested

---

88. *See Saikewicz,* 373 Mass. at 754, 370 N.E.2d at 432. "To the extent that this formulation equates the value of life with any measure of the quality of life, we firmly reject it." *Id.*

89. Some commentators have expressed fear that decisions concerning life quality would place the state on a tightrope where protection of life depends on judgments of social utility. Robertson, *supra* note 82, at 256; *see also* Note, *The Refusal of Life-Saving Medical Treatment vs. the State's Interest in the Preservation of Life: A Clarification of the Interests at Stake,* 58 WASH. U.L.Q. 85, 106-07 (1980); *1974 Hearings, supra* note 11, at 7.

90. "[This] concept is just one expression of the basic tenet that, 'outside areas of plainly harmful conduct, every American is left to shape his own life as he thinks best, do what he pleases, go where he pleases.' " Andrews v. Ballard, 498 F. Supp. 1038, 1048 n.33 (S.D. Tex. 1980) (quoting Kent v. Dulles, 357 U.S. 116, 126 (1958)).

91. "[W]hen danger to health exists . . . state regulation shall be tested under the *rational basis* standard." People v. Privitera, 23 Cal. 3d 697, 703, 591 P.2d 919, 922, 153 Cal. Rptr. 431, 434, *cert. denied,* 444 U.S. 949 (1979) (citing Roe v. Wade, 410 U.S. 113, 163 (1973)) (emphasis in original). *Contra Andrews,* 498 F. Supp. at 1050 n.36. For a different perspective, see *President and Directors of Georgetown College,* 331 F.2d at 1017 (Burger, J., dissenting):

> Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk.

Id. (emphasis in original).

92. For example, if the proposed treatment were painless and unintrusive, it would typically be considered irrational for the patient to wish to die when the costs of preserving his life are so minimal.

93. Compelling blood transfusions, for example, would require little, if any, change in the life quality factor. *See supra* note 84 and accompanying text.

factors are: reductions in functionability;[94] a diminished capacity for enjoyment; diminished capacity for the patient to enjoy human relationships;[95] chronic emotional maladjustment; diminution in physical or cognitive sensation;[96] and other similar losses borrowed from tort law.[97]

G. Hypothetical No. 4 — Utilizing the Life Quality Factor

Taking the same example used in Hypothetical No. 3, we will now factor in the Life Quality variable. Before including the life quality factor, the equation looked like this:

$$\underline{\text{State Concerns}} \qquad \underline{\text{Patient's Concerns}}$$
$$(3) \times (1/3) \quad = \quad 1 \quad \Leftrightarrow \quad (3) \times (1/6) \quad \times (.60) \times (3) = \quad .9$$
$$1 \quad \Leftrightarrow \quad .9$$

Assume for this example that the quality of the patient's life is essentially unchanged. Since pain and suffering are already factored into the equation, they will not have a bearing on the life quality factor, especially where the bodily functions of our patient (with the exception of his immune system) are intact. He enjoys full cognitive and physical awareness and has the capacity for full movement. Aside from his painful condition, assume that his life quality has changed very little, perhaps reduced by only 10%. Restating this in terms suitable for use in the equation, our hypothetical patient's life quality is 90% of what it was before the advent of the terminal condition.[98] The life quality factor is the *inverse* of the degree of the pa-

94. One commentator has suggested that there is no justification "for coercive intrusion by the state in those life-or-death situations . . . in which . . . there is less than a high probability that the nonexperimental treatment will enable the [patient] to pursue either a life worth living or a life of relatively normal healthy growth . . . ." Goldstein, *supra* note 11, at 653.

95. McCormick, *To Save or Let Die, The Dilemma of Modern Medicine*, 229 J. A.M.A. 172, 175 (1974).

96. Some life-preserving treatments which can lead to, or aggravate physical handicaps and impair mental development have been criticized as unjustifiable. *See, e.g., In re* Phillip B., 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979), *cert. denied*, 445 U.S. 949 (1980); *In re* Cicero, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (N.Y. Sup. Ct. 1979).

97. *See, e.g.*, Personal Injury Desk Book 1984 774-80 (J. Nates & D. Axelrod eds. 1984) (cases involving wrongful life); RESTATEMENT (SECOND) OF TORTS § 905 (1977) (nonpecuniary damages related to personal injury); McAlister v. Carl, 233 Md. 446, 197 A.2d 140 (1964) (personal injury action involving mental suffering and nonpecuniary harm); Hogan v. Santa Fe Transp. Co., 148 Kan. 720, 85 P.2d 28 (1938) (loss of enjoyment where injuries rendered plaintiff unable to continue playing the violin).

98. Assume his life quality has been diminished by 10% due to the restrictions and inconveniences caused by his treatment, and that his activities are curtailed because of the painfulness of his condition.

tient's life quality. In this hypothetical, that value would be (1/.90). The revised equation looks like this:

State Concerns		Patient's Concerns
(3) × (1/3)	⇔	(3) × (1/6) × (.60) × (3) × (1/.90)
= 1	⇔	=.99

RESULT: State concerns still prevail.

However, if this patient's life quality is instead diminished to 50% of what it once was, the result is appropriately different:

State Concerns		Patient's Concerns
(3) × (1/3)	⇔	(3) × (1/6) × (.60) × (3) × (1/.50)
= 1	⇔	= 1.80

RESULT: Patient's concerns prevail.

H. Handling Cases Involving Long Life Expectancy

One of the most obvious contingencies in the foregoing hypotheticals is the state interest in cases involving long life expectancy. The equation utilizes the inverse of the patient's life expectancy; the longer the patient is expected to live, the lower the value of his total concerns, or the greater the state interest. This is logical if the state's true interest is in fact that of preserving life.

Practical problems arise, however, because a long life expectancy could conceivably thwart all of the other factors weighing on the patient's behalf. All other factors being equal, the young age of particular patients and the unusual circumstances surrounding their condition could combine to discriminate against them on the basis of age. We have laws prohibiting age discrimination in such mundane affairs as employment. Therefore, it is presumably undesirable to discriminate in the exercise of an important constitutional right on the basis of age.[99] The following hypothetical is illustrative.

I. Hypothetical No. 5 — Long Life Expectancy and Ineffective Treatment

For purposes of this example, assume that the patient is 24 years old and expected to live for 40 more years. Assume also that the prognosis and treatability of his condition are certain, and the rele-

99. For example, discriminatory treatment of disabled newborns is prohibited by federal law. In 1983, President Reagan's memorandum to the Secretary of Health and Human Services (HHS) cited a Baby Doe case and noted that discrimination against the handicapped is illegal. In response, HHS issued regulations that would terminate federal funds to health care providers who refuse to treat handicapped infants. 48 Fed. Reg. 9,630 (1983). Since then, however, one court has nullified this action, finding that HHS regulations were promulgated in an arbitrary and capricious manner in violation of federal statutory law. American Academy of Pediatrics v. Heckler, 561 F. Supp. 395 (D.D.C. 1983). Since this nullification, the government has expressed its continuing desire to take action pursuant to the regulations. *See* 45 C.F.R. § 84.55 (1984) (revision of HHS Regulations).

vant medical certainty factor is 90%. The patient is competent and suffering greatly; his desire to be removed from life support is maximum due to the painful and miserable future which awaits him. In short, this unfortunate patient has everything in the equation, except his age, working in favor of his desire to die. The life quality factor is a low 40% because his affliction has been grave and debilitating, and treatment is highly intrusive and painful. Because of his unusually lengthy life expectancy, however, his interests will be overshadowed by those of the state:

State Concerns		Patient's Concerns
$(3) \times (1/3)$	$\Leftrightarrow$	$(3) \times (1/40) \times (.90) \times (3) \times (1/.40)$
$= 1$	$\Leftrightarrow$	$= .5$

RESULT: State interest prevails.

This analysis seems to present a clear case of age discrimination. If the patient were expected to live for a shorter time and all other variables remained unchanged, the patient's interests would prevail.[100] It is sensible that an increased life expectancy results in an enhanced state interest.[101] However, the equation as presently structured appears to ignore the plight of this isolated class of young patients.

There is no conscionable reason why the suffering of younger or more uniquely afflicted[102] patients should be discounted under otherwise identical circumstances. It has been suggested that one of the

100. *See supra* Hypothetical No. 4, wherein the patient's interest prevails despite a six-year life expectancy.

101. When the patient is terminal, neither his family nor the state should be concerned with the hopelessly elusive question of whether life is worth living. It is enough merely to concede that an individual need not prolong the dying process. P. RAMSEY, ETHICS AT THE EDGES OF LIFE: MEDICAL AND LEGAL INTERSECTIONS 1-14 (1978). On the other hand, when a nonterminal but chronically ill, debilitated, or comatose patient is involved, the question of removal requires society to either struggle with insoluble problems of statutory drafting, or remove all legal prohibition of suicide, or assisting in suicide, when the affected individual or his family concludes that life is no longer worth living. The former alternative logically leads to repugnant advice concerning the lives of several hundred thousand retarded persons. The latter displays a conspicuous insensitivity to the plight of depressed or mentally disturbed persons. Sherlock, *For Everything There is a Season: The Right to Die in the United States,* 1982 B.Y.U. L. REV. 545, 560 (1982). The result of this dilemma is that the state interest in preserving life increases along with the patient's life expectancy. This is due to overzealous application and the fear of consequential totalitarian overtones which accompany removal of nonterminal patients from life support. *See supra* note 63 and accompanying text.

102. For example, older patients who have longer life expectancies because of their debilitated but nonterminal condition could be grouped in the same class as younger patients.

state's concerns in right-to-die cases is that of preventing irrational self-destruction.[103] Thus, if there is evidence accrued over a substantial time period that the patient's decision is a rational one, we might be more inclined to prioritize his decision even though he is expected to live a long life. This is especially true where the patient is failing to adjust to his condition and there is little hope for his physical and psychological recovery.[104]

Suppose the same patient in Hypothetical No. 5 above remains physically and psychologically unchanged after two years of compelled life-sustaining treatment. Is it sensible to continue his compelled treatment for a possible thirty-eight more years? Would we not be satisfied after two years of no psychological or physical adjustment to the treatment that the patient's continued desire to die is a competent decision and not one attributable to mere depression or emotional devastation over his condition?[105] Assume we have waited two years for adjustment, for signs of psychological recovery,[106] and for evidence of an improperly attributed decision regarding his request for removal from life-support. We have, in essence, waited for signs of irrationality, but there appear to be none. The patient has been given every opportunity during this time to adjust, recover, and learn to deal with his handicap. If the patient again requests removal, it makes no sense to deny his request and in effect sentence him to thirty-eight more years of unwanted life-support.

If such disturbing results are to be avoided, the equation should be adjusted to handle analogous situations. A factor is needed, at the patient's option, which accounts for the patient's failure to overcome the devastation of his condition. It is manifestly unjust to continue life-support against the patient's wishes for such extensive periods of time where there is no longer a reasonable fear that the decision to

---

103. *See supra* note 33 and accompanying text.

104. For a moving literary treatment of a case such as this, see B. CLARK, WHOSE LIFE IS IT ANYWAY? (1980) (involving the plight of a sculptor who became totally paralyzed during middle age as the result of an accident).

105. *See, e.g., In re* Yetter, 62 Pa. D. & C. 619 (1973).

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

Id. at 623 (footnote omitted).

106. *See* E. KUBLER-ROSS, ON DEATH AND DYING 38-147 (1969). Kubler-Ross separates the patient's reactions to and handling of death into five stages: 1) denial and isolation; 2) anger; 3) bargaining; 4) depression; and 5) acceptance. Application of this information may help in deciding when to allow patients self-determination.

discontinue treatment is a hasty one, or brought about by depression, shock, or temporary emotional despondency.[107] Therefore, a new optional factor termed the "adjustment potential" variable will be utilized in the equation. This variable will be the inverse of the likelihood of the patient's future adjustment, where 1.0 represents maximum adjustment potential.[108] The variable's value could possibly be determined in the early stages of treatment by statistical inquiries.[109] This has the effect of raising a presumption in favor of adjustment in the early stages of treatment. Indeed, there are numerous cases in which individuals have overcome tremendous handicaps and debilitative conditions to lead productive, rewarding, and well-adjusted lives.[110]

Because of the encouraging examples set by handicapped persons and the typically unconquerable human spirit, it would be difficult not to hope for the best in the beginning and anticipate the patient's ultimate adjustment to the treatment. There may be cases, however, where the available medical information indicates an extremely poor likelihood of adjustment,[111] and statistical data corroborate a low likelihood of the patient's adjustment or recovery. It may then be acceptable to introduce a factor into the equation to account for low "adjustment potential" at the condition's outset.[112] Otherwise, it would rarely be appropriate to deviate from an initial presumption of high adjustment potential.

J. Hypothetical No. 6 — Patient's Potential for Adjustment

State Concerns Patient's Concerns

$$(3) \times (1/3) \Leftrightarrow (3) \times (1/40) \times (.90) \times (1/.40) \times (1/\text{adjustment potential})$$

107. Decisions attributed to temporary conditions such as shock, depression, or despondency would properly be deemed irrational under existing law and public policy. *See supra* note 33 and accompanying text.

108. As the likelihood of the patient's adjustment increases, the state's interest in preserving life should increase commensurably. An adjusted patient is more likely, if not certain, to live a more meaningful life than an unadjusted patient.

109. Using records and prior case histories, for example, the likelihood of recovery for a similarly-situated patient could be determined by comparison studies. Prior analogous case histories would show the patients' recovery and adjustment patterns.

110. *See, e.g.*, R. JONES, THE ACORN PEOPLE (1976) (a true story about handicapped children and their short-lived but rewarding relationship with a camp counselor).

111. Cancer of the esophagus, for example, has yet to be treated successfully. There are no case histories which document any successful remissions of this disease. *See* Gilbert, O'Connell, Kagan, Rao & Potyk, *The Management of Cancer of the Thoracic Esophagus*, in CONTROVERSIES IN CANCER TREATMENT 86 (T. O'Connell ed. 1981).

112. *See, e.g., id.* at 86-96 (patients diagnosed as suffering from esophageal carcinoma almost invariably die within one year after discovery of the condition).

Assume that the patient is in the initial stages of treatment, and is therefore presumed to have a high likelihood of adjustment. For purposes of this hypothetical, an "adjustment potential" factor of 80% is used as follows:

$$(3) \times (1/3) \Leftrightarrow (3) \times (1/40) \times (.90) \times (3) \times (1/.40) \times (\mathit{1/.80})$$
$$= 1 \Leftrightarrow .5 \times 10/8$$
$$1 \Leftrightarrow = .625$$

RESULT: State concerns prevail.

The adjustment potential is high enough in this example to warrant the state interest in preserving life taking priority over the contrary wishes of the patient. With a high adjustment potential, there is a compelling likelihood that the patient will adjust and eventually assimilate into a handicapped but meaningful life.

Suppose, however, that after two years of life-sustaining treatment the patient has shown no signs of adjustment, psychological assimilation, or any other signs of accepting his condition. He steadfastly persists in his requests to be removed from treatment, and shows continual signs of despondency. He frequently displays destructive or misanthropic behavior to the point of requiring physical restraint for his own protection as well as for the protection of others. Perhaps this example is unduly dramatic. It is not, however, inconceivable, by any means.[113]

The problem faced at this point is determining the desirability of compelled life-support for such a patient. Despite his initially high "adjustment potential," our hypothetical patient has clearly demonstrated a reduced potential for adjustment and an unrelenting desire to be removed from treatment. His life expectancy is, of course, now only thirty-eight years, because two years have passed. It may be helpful to reevaluate the competing interests using an appropriately reduced adjustment factor of 50%. As the likelihood of recovery approaches a mere 50-50 chance, the patient's concerns strengthen in value and eventually prioritize his choice over the now misguided state interest in preserving life.

State Concerns — Patient's Concerns

$$(3) \times (1/3) \Leftrightarrow (3) \times (1/38) \times (.90) \times (3) \times (1/.40) \times (\mathit{1/.50})$$
$$= 1 \Leftrightarrow = .533 \times \mathit{1/.50}$$
$$= 1 \Leftrightarrow = 1.066$$

RESULT: Patient's concerns prevail.

It is an extremely close case, but the result favors the patient in

113. On several occasions in April, Mr. Bartling tried to remove the ventilator tubes. To prevent accidental or deliberate disconnection of the ventilator tubes (or any of the other tubes to which he was attached), Mr. Bartling's wrists were placed in "soft restraints." Despite requests from both Mr. and Mrs. Bartling, Glendale Adventist and Mr. Bartling's treating physicians refused to remove the ventilator or the restraints.
Bartling, 163 Cal. App. 3d at 190, 209 Cal. Rptr. at 221.

this instance because he has shown no signs of adjustment over a two-year period. In such circumstances, the moral hazard of irrational self-destruction, or self-destruction attributable to temporary psychological distress, is minimized.[114]

---

114. In such cases, it might be difficult to distinguish between *protected* beliefs, which are nonetheless "foolish, unreasonable and even absurd . . . ," *President and Directors of Georgetown College*, 331 F.2d at 1017 (Burger, J., dissenting), and unprotected, "irrational self-destruction." *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11. In making this distinction, the personal importance of the treatment, or non-treatment, should be attenuated.

> It is the individual making the decision, and no one else, who lives with the pain and disease. It is the individual making the decision, and no one else, who must undergo or forego the treatment. And it is the individual making the decision, and no one else, who, if he or she survives, must live with the results of that decision. One's health is a uniquely personal possession. The decision of how to treat that possession is of a no less personal nature.

Andrews v. Ballard, 498 F. Supp. 1038, 1047 (S.D. Tex. 1980).

Perhaps the only judicious method for making such a determination is one which prevents self-destruction as the result of a *temporary* or *reversible* state of mind. After the temporariness of the patient's decision has been refuted, there is a danger of encroachment upon constitutionally protected privacy rights which uphold the patient's decisions regarding treatment, whether or not it appears to be in his or her best interest. *See supra* note 105.

The equation therefore favors, after sufficient time for reflection and adjustment has passed, the privacy interests of the patient where it appears that the patient genuinely desires to be removed from treatment despite the consequence of death. A passage from B. CLARK, *supra* note 104, at 141-42, aptly summarizes this point:

> KEN
>
> The cruelty doesn't reside in saving someone or allowing them to die. It resides in the fact that the choice is removed from the man concerned.
>
> JUDGE
>
> But a man who is very desperately depressed is not capable of making a reasonable choice.
>
> KEN
>
> As you said, my Lord, that is the question to be decided.
>
> JUDGE
>
> All right. You tell me why it is a reasonable choice that you decided to die.
>
> KEN
>
> It is a question of dignity. Look at me here. I can do nothing, not even the basic primitive functions. I cannot even urinate, I have a permanent catheter attached to me. Every few days my bowels are washed out. Every few hours two nurses have to turn me over or I would rot away from bedsores. Only my brain functions unimpaired but even that is futile because I can't act on any conclusions it comes to. This hearing proves that. Will you please listen.
>
> JUDGE
>
> I am listening.
>
> KEN
>
> I choose to acknowledge the fact that I am in fact dead and I find the hospital's persistent effort to maintain this shadow of life an indignity and it's inhumane.
>
> JUDGE
>
> But wouldn't you agree that many people with appalling physical handicaps have overcome them and lived essentially creative, dignified lives?
>
> KEN

V. PROBLEM AREAS IN IMPLEMENTATION

A. Agency for the Comatose and Incompetent

Although brain death statutes have solved several problems that existed under traditional handling of comatose and brain dead patients by redefining "death," problems still remain. Some statutes allow a physician to choose the definition of death he prefers or considers appropriate under the circumstances.[115] Other statutes provide that death will be determined by the cessation of brain activity where a patient's cardiac and respiratory functions are artificially maintained.[116] Under other statutes, cessation of both the cardiac and respiratory functions remain the determining factors.[117] Still other statutes provide that the patient is legally dead upon the total and irreversible cessation of brain function.[118]

Twenty states presently do not have statutory definitions of death. In the absence of such legislation, physicians are apt to apply their own definitions of death on an ad hoc basis or attempt to anticipate the courts' definition. Moreover, existing brain death statutes do not adequately define death. Under all current statutes, a patient may be legally considered "alive" and yet have brain damage so severe that he exists without perception, consciousness, or emotion. To compensate for the inadequacies and uncertainties which still exist in the law, such patients are increasingly being forced to assert the right to die through their guardians.

A guardian may, in some instances, assert the right to die on the patient's behalf.[119] The problem which arises is determining under

---

Yes, I would, but the dignity starts with their choice. If I choose to live, it would be appalling if society killed me. If I choose to die, it is equally appalling if society keeps me alive.

115. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1985); COLO. REV. STAT. § 12-36-136 (Supp. 1984); GA. CODE ANN. § 31-10-16 (1985); IDAHO CODE § 54-1819 (Supp. 1985); KAN. STAT. ANN. § 77-205 (1984); ME. REV. STAT. ANN. tit. 22, § 2811 (Supp. 1984); MD. PUB. HEALTH CODE ANN. § 5-202 (Supp. 1984); MISS. CODE ANN. § 41-36-3 (1981); MONT. CODE ANN. § 50-22-101 (1983); N.M. STAT. ANN. § 12-2-4 (1978); N.C. GEN. STAT. § 90-323 (1981); OR. REV. STAT. § 146.001 (1983); R.I. GEN. LAWS § 23-4-16 (Supp. 1984); TENN. CODE ANN. § 68-3-501 (1983); VT. STAT. ANN. tit. 18, § 5218 (Supp. 1984); VA. CODE § 54-325.7 (1982); WIS. STAT ANN. § 146.71 (West Supp. 1984).

116. ALA. CODE § 22-31-1 (1984); ALASKA STAT. § 09.65.120 (1983); FLA. STAT. ANN. § 382.085 (West Supp. 1983); IOWA CODE ANN. § 702.8 (West 1979); LA. REV. STAT. ANN. § 9:111 (West Supp. 1985); MICH. COMP. LAWS ANN. § 333.1021 (West 1980); MO. ANN. STAT. § 194.005 (Vernon 1983); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1985).

117. ARK. STAT. ANN. § 82-537 (Supp. 1983); OKLA. STAT. ANN. tit. 63, § 1-301(g) (West 1984).

118. NEV. REV. STAT. § 451.007 (1983); W. VA. CODE § 16-10-2 (1985); WYO. STAT. § 35-19-101 (Supp. 1985).

119. *See Quinlan*, 70 N.J. at 41, 355 A.2d at 664 ("[w]e have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present."); *but cf. Saikewicz*, 373 Mass. at 757, 370 N.E.2d at 433 (the

what circumstances such agency may be effective in asserting the patient's right. The same concerns arising where a competent individual is asserting the right for himself are even more important in cases involving assertion through an agent or guardian. The guardian cases certainly create a moral hazard,[120] as well as a justifiable doubt regarding the certainty of a decision made for, rather than by, the patient. Is the decision to terminate treatment attributable to the patient's wishes or to the wishes of the agent? Is the decision simply attributable to the vegetative condition of the patient? May the decision be justified by the fact that the patient is unable to enjoy a conscious and sapient life?

B. The Guardian Cases

It is probably easiest to understand the issues involved in the assertion of the right to die through a guardian in the context of specific cases. Although there have been a number of cases dealing with an individual's right to terminate treatment, three deserve special consideration. *In re Quinlan*[121] and *Superintendent of Belchertown State School v. Saikewicz*[122] have established the foundation upon which most courts base their decisions in dealing with cases in this area. Consideration will also be given to *Barber v. Superior Court*,[123] in which, for the first time, attending physicians were charged with murder for disconnecting the life-support of a patient in a persistent and chronic coma.[124]

1. The *Quinlan* Case

Karen Quinlan suffered from a condition which was diagnosed as chronic, persistent, and vegetative. Doctors conceded from the beginning that no cure existed for Karen Quinlan, and that she would never be restored to a conscious state. She could not, however, be le-

guardian has the responsibility to present to the judge "all reasonable arguments in favor of administering treatment to prolong the life of the individual involved.").

120. Absent medical agreement about what treatment is indicated, or absent a societal consensus about the rightness of the predicted result of treatment, there would be no justification for disqualifying parents from (or for qualifying agents of the state for) making the difficult choice . . . . Put somewhat more starkly, how can parents in such situations give the wrong answer since there is no way of knowing the right answer?

Goldstein, *supra* note 11, at 654-55.

121. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

122. 373 Mass. 728, 370 N.E.2d 417 (1977).

123. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

124. American Medical News, Sept. 16, 1983, at 13.

gally declared dead.[125]

On the basis of this prognosis, Karen's father petitioned the New Jersey Superior Court to have himself appointed as Karen's guardian and to allow him to authorize the termination of all extraordinary medical procedures sustaining her life. He also requested the court to grant immunity from criminal prosecution to anyone effectuating the termination of treatment.[126] The trial court denied the relief sought and the case was appealed.

Because Karen could not exercise her own right to die, the appellate court was confronted with the issue of whether such a right could be implemented by a guardian on behalf of an incompetent patient. Reasoning that a patient in such a state would otherwise be incapable of exercising this fundamental right, the court held that a guardian could assert the right to die for an incompetent patient.[127] The guardian may assert this right, however, only where it is shown that the patient would choose to exercise the right to terminate treatment under the particular facts presented by the patient's condition.[128] The court also noted that the state's interest in preserving life and the right of a physician to administer medical treatment in accordance with his best judgment were to be weighed against Karen's right to die.

The court determined that the state's interest weakens and the individual's right to privacy grows as the degree of bodily intrusion increases and the prognosis dims.[129] Because Karen's prognosis was dismal and the bodily invasions by intravenous tubes, antibiotics, and a respirator were great, the court held that Karen's right to privacy outweighed the state interest.[130]

The *Quinlan* court also reached the issue of whether anyone who disconnected Karen's respirator would be subject to criminal liability for homicide. Although the court acknowledged that the termination of treatment would accelerate Karen's death, it nevertheless held the act would not constitute criminal homicide because the ensuing death would not have resulted from anything other than "existing natural causes."[131] Furthermore, even if the death were to be regarded as a homicide, it would not be unlawful because the exercise of a constitutional right is protected from criminal prosecution.[132] This "constitu-

125. She apparently did not meet the necessary legal criteria to be declared dead under operative law at the time. *See Quinlan*, 70 N.J. at 20, 355 A.2d at 652.

126. *In re* Quinlan, 137 N.J. Super. 227, 236, 348 A.2d 801, 806 (1975), *modified*, 70 N.J. 10, 355 A.2d 647 (1976).

127. *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976).

128. *Id.*

129. *Id.* at 40-41, 355 A.2d at 663-64.

130. *Id.* at 41, 355 A.2d at 664.

131. *Id.* at 51, 355 A.2d at 669-70.

132. *Id.* at 52, 355 A.2d at 670. *See also* Stanley v. Georgia, 394 U.S. 557, 559 (1969).

tional protection extends to third parties whose action is necessary to effectuate the exercise of that right. . . ."[133]

2. The *Saikewicz* Case

Joseph Saikewicz was a 67-year-old severely retarded man suffering from incurable and terminal acute leukemia. Doctors prescribed chemotherapy treatment, but it offered little or no hope of a cure. Moreover, the treatment would produce significant adverse side effects and discomfort while providing only a slight chance of remission. Patients in similar situations generally chose to suffer those side effects in hope of a remission, rather than let the disease go untreated.[134]

Upon the suggestion of the attending physicians, a petition was filed with the Massachusetts Probate Court for appointment of a guardian to make decisions regarding Mr. Saikewicz's treatment. The appointed guardian requested that no treatment be prescribed for Mr. Saikewicz.[135] The probate court agreed with the guardian's reasoning that the inability of Mr. Saikewicz to "understand that treatment to which he would be subjected and the fear and pain he would suffer as a result, outweighed the limited prospect of any benefit from such treatment. . . ."[136] The court then applied for direct appellate review by the Massachusetts Supreme Court.[137]

The *Saikewicz* opinion, like *Quinlan,* recognized the substantive right of both competent and incompetent persons to decline potential life-prolonging treatment.[138] A guardian would therefore have capacity to assert such rights on behalf of patients unable to do so for themselves. Both courts found the state interests failed to outweigh the patient's right to privacy.[139] The only state interest found applicable by the *Saikewicz* court was the preservation of human life.[140] The court concluded, however, that this interest could be given little priority in light of Mr. Saikewicz' dismal medical prognosis.[141]

133. *Quinlan,* 70 N.J. at 52, 355 A.2d at 670.
134. *Saikewicz,* 373 Mass. at 733-34, 370 N.E.2d at 421.
135. *Id.* at 730, 370 N.E.2d at 419.
136. *Id.*
137. As did Francis Bartling, *see supra* note 3 and accompanying text, Joseph Saikewicz died prior to the hearing before the high court. 373 Mass. at 735, 370 N.E.2d at 422.
138. *Id.* at 740, 370 N.E.2d at 424. The rights determined to be applicable to the decision to decline treatment were the individual privacy rights of the patient.
139. *Id. See also Quinlan,* 70 N.J. at 39, 355 A.2d at 647.
140. *Saikewicz,* 373 Mass. at 744, 370 N.E.2d at 427.
141. *Id.*

Upon determining that patients such as Mr. Saikewicz have the right to decline treatment, the court adopted a "substituted judgment" rule[142] to decide how a legally incompetent patient would exercise his right to die.[143] Courts would determine whether a patient could exercise the right to die through an evaluation of the patient's "actual interests and preferences."[144]

3. The *Barber* Case

In August, 1981, Clarence Herbert suffered a cardiopulmonary arrest following the completion of routine surgery. Although he was immediately placed on life-support, his physicians determined that Mr. Herbert had suffered severe brain damage due to lack of a normal oxygenated blood flow to the brain, and that he was in a deep comatose state likely to be permanent. After learning of Mr. Herbert's condition and his slim chances of recovery, his family drafted a request that the hospital remove all life-sustaining machines. Their letter indicated that no one carrying out their request would be held liable.[145]

Despite recommendations to first seek legal advice, Doctors Barber and Nejdl removed the respirator approximately seventy-two hours after Mr. Herbert's cardiopulmonary arrest. The patient continued to breathe without the assistance of the respirator, but there were no signs that his condition would improve. After further consultation with the Herbert family, the doctors ordered the removal of the intravenous tubes which provided the patient with hydration and nourishment.[146] Eleven days after entering a coma, Mr. Herbert died.

Doctors Barber and Nejdl were subsequently charged by the State of California with murder and conspiracy to commit murder. The superior court found the charges to be supported by evidence that the doctors' conduct had shortened Mr. Herbert's life, "since everyone, sooner or later will die, homicide is simply the shortening of life by some measurable period of time."[147] Therefore, because the physicians' "intentional conduct, which shortened Mr. Herbert's life, was not authorized by law, it constituted murder."[148] The California Court of Appeal ultimately dismissed the complaint against the physicians.

The appellate court first addressed California's Natural Death

142. *Id.* at 751-53, 370 N.E.2d at 431-32.
143. *Id.* at 752, 370 N.E.2d at 431.
144. *Id.*
145. Barber v. Superior Court, 147 Cal. App. 3d 1006, 1010, 195 Cal. Rptr. 484, 486 (1983).
146. *Id.*
147. *Id.* at 1012, 195 Cal. Rptr. at 487.
148. *Id.*

Act,[149] which provides that an adult may execute, in advance of terminal illness, a directive for withholding or withdrawing life-sustaining treatment in the event he or she later becomes terminally ill.[150] The trial court had reasoned that because of the availability of such a procedure, and because Mr. Herbert had not executed a directive to this effect, the family's request for termination was a nullity and the physicians therefore acted unlawfully.[151] In rejecting this reasoning, the appellate court noted that the procedure provided in the statute was not intended to impair or supersede the legal right to withdraw life-support equipment.[152]

Having found that the patient had the recognized statutory right to refuse treatment, the court had only to determine whether the physicians' actions were unlawful. The court concluded that disconnecting the intravenous devices was no different than withholding a manual injection and, therefore, the disconnection was an omission rather than an affirmative act.[153] The court consequently determined that the case ultimately turned on whether Doctors Barber and Nejdl had a duty to provide *continuous* life-sustaining treatment.[154]

The three-judge panel concluded that "[a]lthough there may be a duty to provide life-sustaining machinery in the *immediate* aftermath of cardio respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel."[155] In determining the futility of treatment, the court proposed a balancing test to weigh the benefits of continued treatment against the hopelessness of the patient's prognosis. Because Mr. Herbert had a hopeless future, and because treatment was merely forestalling death rather than enabling a return to a "normal" existence, the court held that the physicians were under no legal duty to continue life-supporting treatment.[156]

---

149. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985).

150. *Id.* § 7188.

151. 147 Cal. App. 3d at 1015, 195 Cal. Rptr. at 489.

152. CAL. HEALTH & SAFETY CODE § 7193 (West Supp. 1985).

153. 147 Cal. App. 3d at 1017, 195 Cal. Rptr. at 490. Such an omission could only be considered unlawful if there was an existing legal duty not to omit such treatment. *Id.*

154. *Id.*

155. *Id.* at 1017-18, 195 Cal. Rptr. at 491 (emphasis in original).

156. *Id.* at 1020, 195 Cal. Rptr. at 492. The court noted in dicta that, in the absence of legislative guidance, there was no legal requirement of prior judicial approval before any effectuation of a decision to withdraw treatment. *Id.* at 1020-21, 195 Cal. Rptr. at 492-93. *See also Bartling,* 163 Cal. App. 3d at 197, 209 Cal. Rptr. at 226.

C. *Adjusting the Equation in Guardian Cases*

In order to respond to the administrative difficulties and legal uncertainties in allowing patients to effectively assert their right to die, there is a need to develop a uniform approach in delineating the nature and effect of the competing interests involved. Such rights must be prioritized to achieve uniform but conscionable results.

With the proper adjustments, the proposed equation may also be used effectively in deciding guardian cases. The substituted judgment rule espoused in *Saikewicz* is fine if information pertaining to the patient's "actual interests and preferences"[157] could *always* be available apart from inherent conflicts of interest.[158] Without such knowledge, the equation affords objective assistance by taking into account any element of doubt as to the patient's preferences.[159]

D. *Hypothetical No. 7 — Accounting for Unknown Patient Preferences*

Assume for this example that our patient is fairly young and in a comatose state. Although on life-support, she is expected to live for another fifteen years with 90% medical certainty. The treatment is highly intrusive, although arguably painless, due to the unconscious condition of the patient. Because there is little or no hope of successfully reversing the coma and it is doubtful that the patient will ever be restored to a cognitive state, the life quality factor drops to a low 20%. There is genuine uncertainty as to the patient's preference since no living friend or relative has information sufficient to assert that the patient would desire removal of life support. Therefore, the factor measuring the patient's desire to live should be assigned a middle range value of 2 because other cases involving patients similarly

---

157. *See supra* note 144 and accompanying text.

158. Medical care in guardian cases often hinges upon whether the parents or guardians desire to pursue treatment in light of their socioeconomic and emotional state. Goldstein, *supra* note 11, at 645. Conversely, the decisionmaker today is not without pressure toward a pro-life position from public outcry and fear of civil and criminal liability. *See, e.g., Bartling*, 163 Cal. App. 3d at 192, 209 Cal. Rptr. at 224; *Barber*, 147 Cal. App. 3d at 1011, 195 Cal. Rptr. at 487. Thus, many factors in conflict with the patient's "actual interests and preferences" bear on the decisionmaking process of guardians and attending physicians. "Families . . . may have mixed motives. They may demand death to obtain relief from the high costs and tensions inherent in suffering, but their sense of guilt in this thought may produce the opposite demand, perhaps in violation of the sick person's rights." Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890, 893 (1973).

For additional commentary and proposals to ensure reasoned family decisionmaking, see Comment, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 NW. U.L. REV. 172 (1981).

159. An objective analysis adopted by the courts would minimize the potential guilt feelings of the decisionmaker, assure consideration of the state's interest in life, and promote uniform treatment of incompetent patients.

situated have shown them to prefer removal.[160] The final analysis looks like this:

State Concerns			Patient's Concerns			
(state interest in preserving life)	× (1/intrusion)	⇔	(patient's desire to be removed)	× (1/years expected to live)	× (degree of medical certainty)	
		×	(pain & suffering)	× (1/life quality)	× (1/likelihood for improvement)[161]	
	(3) × (1/3) = 1	⇔	(2) × (1/15) × (.90) × (1) × (1/.20) × (1/.30)[162] = 2			

RESULT: Patient's concerns prevail.

E. Hypothetical No. 8 — Less Intrusive Treatment

Although less intrusive treatment would rarely include life-support, there are cases where such treatment, necessary for the patient's continuing health, may be compelled over parental, religious, or other objections.[163] Thus, cases involving less intrusive treatment

---

160. Evidence that most people would or would not act in a certain way is certainly an important consideration in attempting to ascertain the predilections of any individual, but care must be taken, as in any analogy, to ensure that operative factors are similar or at least to take notice of the dissimilarities. . . . Evidence that most people choose to accept the rigors of chemotherapy has no direct bearing on the likely choice that Joseph Saikewicz would have made.

Saikewicz, 373 Mass. at 746-48, 370 N.E.2d at 429-30.

Moreover, where the patient's desire for removal is so low as to warrant a rating of 1 in the equation, it would be improper to discontinue treatment because the patient's right to life would supersede all other interests. Treatment should not be discontinued where the relevant circumstances include a markedly low desire for removal, or a continuing ambivalence, on the part of the patient.

161. This factor replaces the "adjustment potential" factor discussed above. *See supra* notes 108-14 and accompanying text. Because psychological and emotional adjustment is not an appropriate consideration in cases involving comatose patients, the "likelihood for improvement" factor is substituted for the "adjustment potential" factor to monitor the futility of ongoing treatment. Thus, where the continued treatment is merely expected to preserve the status quo—a comatose, vegetative state—the equation, in the absence of other compelling factors, favors removal. *See Quinlan*, 70 N.J. at 39, 355 A.2d at 663.

162. This factor reflects a mere 30% chance of reversing the coma or restoring the patient to a conscious condition.

163. *See, e.g., In re* Cicero, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Sup. Ct. 1979) (compelling treatment over parental objection); John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971) (compelling treatment over religious objection); Mills v. Rogers, 457 U.S. 291, 299 (1982) (considering whether one can avoid the unwanted administration of antipsychotic drugs); *In re* Yetter, 62 Pa. D. & C. 619, 620-21 (1973) (refusing to compel diagnostic/corrective surgery involving a breast biopsy).

may appropriately be considered here even though they do not fall within the boundaries of traditional right-to-die analysis.

Consider a case where the treatment of a minor patient is less intrusive. Suppose daily injections are required to sustain the patient and, aside from some painful side effects, he is able to fuction normally, enjoying a high life quality factor of 80%. However, his life expectancy, due to age and condition, is only ten years. Because treatment is costly and the patient is expected to live for ten more years at the most (his condition and side effects worsen over time), the boy's parents petition to discontinue the painful and expensive treatment. Although the boy also wishes to discontinue the treatment, the law does not consider him competent to make that decision. This case must therefore be analyzed using a guardian approach.

State Concerns				Patient's Concerns		
(state interest in preserving life)	× (1/intrusion)	⇔ (patient's desire to be removed)	×	(1/years expected to live)	×	(degree of medical certainty)
		× (pain & suffering)	×	(1/life quality)	×	(1/likelihood for improvement)

$$(3) \times (1/1) \Leftrightarrow (2) \times (1/10) \times (.90) \times (3) \times (1/.80) \times (1/.30)$$
$$= 3 \Leftrightarrow = 2.25$$

RESULT: State concerns prevail.[164]

VI. The Right to Die for Disabled Newborns and Fetuses

Although the disabled newborn's right to die clearly deserves protection, the legal parameters of this interest are not clear.[165] Advances in medical technology over the past forty years have dramatically decreased the infant mortality rate in the United States.[166] One result of this low mortality rate is that many infants emerge from neonatal intensive care units requiring continual medical treatment. These infants typically receive a dim prognosis for a normal life.[167] Current medical practice in treating the more se-

164. This result is not without opposition. Problems arise with the countervailing constitutional privacy rights of the family. *See infra* notes 180-94 and accompanying text. Additional problems arise concerning the privacy rights of the neonatal patient. Widespread common law recognition of both the competent and incompetent non-infant's right to refuse life-sustaining medical treatment suggests that a similar right to refuse such treatment should be recognized for severely disabled infants. *See* Parness & Stevenson, *Let Live and Let Die: Disabled Newborns and Contemporary Law*, 37 U. Miami L. Rev. 43 (1982).

165. For a comprehensive treatment of issues specifically involving the treatment and nontreatment of disabled newborns in the United States, see generally Parness & Stevenson, *supra* note 164.

166. Duff & Campbell, *supra* note 158, at 890-91.

167. *See* Ellis, *supra* note 38, at 420; *see also* Parness and Stevenson, *supra* note 164, at 45-50.

verely afflicted newborns varies disturbingly.[168]

Certain medical practitioners will inevitably seek to treat severely disabled newborns regardless of the nature of the treatment, the dimness of the prognosis or contrary parental desires. However, the nontreatment of such newborns is a common occurrence in hospitals and other health care facilities across the country.[169] Some argue that nontreatment may be "good medical practice" in some cases.[170] Although nontreatment may be common, those who decide to treat the disabled infant lack consistency in approaching seemingly identical problems.[171]

These divergent views frame the issue. Should treatment be compelled in all cases, or may a disabled infant exercise the right to die? As noted earlier, the right to die for non-infants already seems rooted in the common law,[172] for just as the guarantee of the right to privacy "reaches out to protect the freedom of a woman to terminate pregnancy under certain conditions . . . so it encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances."[173] Such recognition of both the competent and incompetent non-infant's right to refuse life-sustaining treatment suggests that a similar right should be recognized for severely disabled newborns.[174] It has been noted, however, that applying this suggestion has its problems.[175]

As previously noted, courts have allowed patients to refuse treatment based on the severity of the resulting bodily intrusion.[176] Disabled newborns, however, cannot make their own decisions and, of course, cannot assert their right of privacy to avoid significant bodily intrusions. In severe cases, disabled infants may require institutionalization with no hope of ever seeing the outside world. Dependency

168. *See* Parness and Stevenson, *supra* note 164, at 45-50.

169. *1974 Hearings, supra* note 11.

170. Robertson, *supra* note 82, at 214. *But see* Strong, *The Tiniest Newborns,* 13 HASTINGS CENTER REP. 14 (1983) (finding no compelling arguments in favor of withholding aggressive treatment of infants with very low weight at birth).

171. A prominent physician testifying before Congress stated that "[i]t is disquieting to discover that infants apparently have an identical condition and may be treated differently, and some may survive and some not." *1974 Hearings, supra* note 11, at 17 (statement of Dr. Raymond S. Duff); *see also Is There a Right to Die—Quickly?,* 80 J. PEDIATRICS 904, 905 (1972) (two divergent opinions regarding treatment of children born with meningomyeloceles).

172. *See supra* notes 125-56 and accompanying text.

173. *Saikewicz,* 373 Mass. at 739, 370 N.E.2d at 424 (citations omitted).

174. Parness & Stevenson, *supra* note 164, at 54.

175. *Id.* at 57.

176. *See supra* note 54.

on narcotic medication and medical machinery is not uncommon. Necessary treatment can lead to, or aggravate, physical handicaps and impair mental development.[177] Lack of competence or ability to voice an objection to treatment should not preclude termination of an infant's painful life in certain circumstances. The severely disabled newborn should have the same privacy right as the severely disabled adult.

Since the infant's decisionmaker is subject to criminal or civil liability,[178] courts and legislators must afford protection not only to the newborn but also to the decisionmaker. Some commentators suggest that court approval minimizes the guilt feelings of the decisionmaker, assures consideration of the state interest in preserving life, and facilitates the uniform treatment of disabled newborns.[179]

A. The Competing Interests

The constitutional rights of parents to make decisions concerning their children stem from the fourteenth amendment's concept of personal liberty[180] and the penumbral right to privacy.[181] The state may not deprive a parent of custody, for example, without a sufficient showing of imminent harm[182] or parental unfitness, even if it would incontrovertibly be in the child's best interest.[183] The Supreme Court has stated that parental autonomy is sacrosanct and that "custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."[184]

This is not to say that a court is by any means powerless to overrule parental decisions. Parental autonomy is not absolute. The California Court of Appeal has noted that "the state has a right, indeed, a duty, to protect children."[185] State officials may intervene in family matters to safeguard childrens' health, education and emotional well-

177. *See, e.g., In re* Phillip B., 92 Cal. App. 3d 796, 800, 156 Cal. Rptr. 48, 50 (1979), *cert. denied*, 445 U.S. 949 (1980); *Cicero*, 101 Misc. 2d at 700, 421 N.Y.S.2d at 967.

178. *See supra* note 158.

179. Parness & Stevenson, *supra* note 164, at 60.

180. Roe v. Wade, 410 U.S. 113, 153 (1973) (married women have right to procure abortion).

181. *See* Griswold v. Connecticut, 381 U.S. 479, 484-85 (1965); Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925); Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

182. *In re* Baby Girl M., 37 Cal. 3d 65, 688 P.2d 918, 207 Cal. Rptr. 309 (1984) ("detriment standard" used in custody award decision under Family Act allowing state intervention when imminent harm to the child is present).

183. Santosky v. Kramer, 455 U.S. 745 (1982) (clear and convincing evidence of neglect required for termination of parental rights in natural child).

184. Prince v. Massachusetts, 321 U.S. 158, 166 (1944).

185. *Phillip B.*, 92 Cal. App. 3d at 801, 156 Cal. Rptr. at 51. *See also* Parham v. J.R., 442 U.S. 584, 604 (1979).

being.[186]

> One of the most basic values protected by the state is the sanctity of human life. . . . Where parents fail to provide their children with adequate medical care, the state is justified to intervene. However, since the state should usually defer to the wishes of the parents, it has a serious burden of justification before abridging parental autonomy by substituting its judgment for that of the parents.[187]

In determining whether parental autonomy should be abridged, courts have considered such factors as the seriousness of the condition requiring treatment,[188] the risks inherent in the proposed treatment,[189] the wishes of the minor (if such are known), and the benefits of the treatment.[190] Judicial preemption of parental autonomy is appropriate only when the child's physical condition is in imminent danger of becoming impaired and his welfare demands judicial intervention.[191] If there is uncertainty regarding the benefit of the treatment or the welfare of the infant, the interest of the family should prevail. If the best interests of the child or the correct course of action are not self-evident, the family's decision should not be supplanted by that of a court.

> Families know their values, priorities and resources better than anyone else. Presumably they, with the doctor, can make the better choices as a private affair. Certainly, they, more than anyone else, must live with the consequences. Most of these families know they cannot place that child for adoption because no one else wants the child. If they cannot cope adequately with the child and their other responsibilities and survive as a family, they may feel that the death option is a forced choice. . . . But that is not necessarily bad, and who knows of a better way.[192]

Notwithstanding the state's obligation to protect the child, a family's decision deserves great deference. Competing with the state interest in preserving life and protecting children are the endangered privacy interests of newborns, parents and other family members.[193] If these privacy rights are to have any meaning or effect, the state

186. *See, e.g., In re* Sampson, 65 Misc. 2d 658, 670-71, 317 N.Y.S.2d 641, 654 (Fam. Ct. 1970). For a review of cases involving children's, parent's, and family rights, see Wingo & Freytag, *Decisions Within the Family: A Clash of Constitutional Rights*, 67 IOWA L. REV. 401 (1982); Keiter, *Privacy, Children, and Their Parents: Reflections On and Beyond the Supreme Court's Approach*, 66 MINN. L. REV. 459 (1982).

187. *Phillip B.*, 92 Cal. App. 3d at 801-02, 156 Cal. Rptr. at 51 (citation omitted).

188. *See, e.g., In re* Brooklyn Hosp., 45 Misc. 2d 914, 258 N.Y.S.2d 621 (Sup. Ct. 1965).

189. *See, e.g., Phillip B.*, 92 Cal. App. 3d at 802, 156 Cal. Rptr. at 52.

190. *See, e.g., Mills*, 457 U.S. at 297-98.

191. *Cicero*, 101 Misc. 2d at 701-02, 421 N.Y.S.2d at 967-68.

192. Goldstein, *supra* note 11 at 656 (quoting Kelsey, *Shall These Children Live? A Conversation With Dr. Raymond S. Duff*, 72 REFLECTION, Jan. 1975 at 4, 7 (published by Yale Divinity School)).

193. *See generally* Wingo & Freytag, *supra* note 186; Keiter, *supra* note 186.

must show compelling justification for their preemption. As medical capabilities continue to progress in defiance of mortality, the state's burden of justification will decrease to a point where the privacy interests, as presently defined, will become legal fictions. For this reason, the law must keep abreast of advancements in medical science to ensure that privacy rights are redefined accordingly.[194]

B. *Problems in the Future: Advancements in Medicine May Vitiate Privacy*

As discussed previously, state interests may override individual privacy rights where compelled treatment requires lesser degrees of bodily intrusion.[195] It is likely that future advancements in medical technology will continue to improve treatment methods and reduce the accompanying bodily intrusions.[196] At some unknown time in the future, it may be medically possible to perform surgeries, biopsies, tissue removals, and the like without the degree of bodily intrusion required by present procedures. Continued progress in medicine, however, will certainly diminish the privacy rights of future patients confronted with life and death decisions.

Within the past ten years, courts have struggled with cases involving the right to life of incompetent persons who need medical treatment to stay alive. From such decisions a consensus has emerged: in certain cases, the right to life is so strong that contrary privacy interests cannot overcome it. This right to life exists where medical treatment preserves life rather than merely prolongs it,[197] produces little, if any, pain and suffering, and constitutes no significant bodily intrusion.[198]

The state interest in preserving life is not presently dependent on the consent of the individual whose life is to be preserved. The state

---

194. For a history of recent unsuccessful regulatory attempts by the Reagan Administration, see American Academy of Pediatrics v. Heckler, 561 F. Supp. 395 (D.D.C. 1983). *See also* 48 Fed. Reg. 30,846 (1983) (to be codified at 45 C.F.R. pt. 84) (proposed July 5, 1983).

There are, however, certain instances where legislation might be both effective and appropriate. *See generally* PRESIDENT'S COMM. FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DEFINING DEATH: A REPORT ON MEDICAL, LEGAL AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH (1981) (commission's attempt to draft and develop a statute establishing a uniform definition of death). *See also* H.R. 6492, 97th Cong., 2d Sess. (1982) (legislation attempting to establish judicial remedies for handicapped infants who die through the deliberate or negligent nontreatment of health care providers); Shapiro, *Medical Treatment of Defective Newborns: An Answer to the "Baby Doe" Dilemma,* 20 HARV. J. ON LEGIS. 137 (1983).

195. *See supra* note 54 and accompanying text.

196. Radiation therapy, laser surgery, orthoscopy, and various "wonder drugs" are recently developed and familiar examples of less intrusive forms of treatment.

197. *See supra* note 61 and accompanying text.

198. *See supra* notes 54 and 57 and accompanying text.

has the power to effectively assert the right to life over the patient who would not otherwise wish to exercise that right, especially where minors and other legally incompetent persons are concerned.[199] Courts have recognized an unassailable state right to preserve life among various categories of incompetent persons. For example, persons incompetent by virtue of their youth have been afforded life-preserving treatment despite parental objections,[200] as have mentally incompetent adults, notwithstanding their inability to consent to such treatment.[201]

C. A Disturbing Conflict: An Overlap of Constitutional Rights

What happens when the intrusion required to remove an embryo and rear it *in vitro* in a laboratory, or transfer it to another womb, becomes lesser than or equivalent to the intrusion necessary to effectuate a present-day clinical abortion?[202] Of course, this inquiry requires revisiting viability concepts much like those dealt with at

199. State *ex rel.* White v. Narick, 292 S.E.2d 54 (W. Va. 1982); Von Holden v. Chapman, 87 A.D.2d 66, 450 N.Y.S.2d 623 (1982) (hunger-striking prisoners can be force-fed). *But cf.* Zant v. Prevatte, 248 Ga. 832, 286 S.E.2d 715 (1982) (court refused to sanction force-feedings of a sane and rational prisoner on a hunger strike because of the intrusive impact of such action on the prisoner's bodily privacy); *see also* Note, *Prisoner Hunger Strikes: Constitutional Protection for a Fundamental Right*, 20 AM. CRIM. L. REV. 569 (1983).

200. The state has met its burden of justification to overcome the parents' decision in cases involving: (1) removal of a malignant eye, *In re* Vasko, 238 A.D. 128, 263 N.Y.S. 552 (1933); (2) transfusion for severe burns, *In re* Brooklyn Hosp., 45 Misc. 2d 914, 258 N.Y.S.2d 621 (Sup. Ct. 1965); (3) transfusion for corrective surgery of grotesque deformities caused by neurofibromatosis, *In re* Sampson, 65 Misc. 2d 658, 317 N.Y.S.2d 644 (Fam. Ct. 1970), *aff'd*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972); and (4) surgical repair of a newborn's meningomyelocele (a protrusion of membrane through a defect in the spinal column), *In re* Cicero, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Sup. Ct. 1979).

201. *See, e.g.*, John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971) (adult may be compelled to submit to blood transfusion despite incompetency and contrary religious beliefs). Deferring to parental autonomy, courts have refused to order treatment in several cases. *See, e.g., In re* Phillip B., 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979), *cert. denied*, 445 U.S. 946 (1980) (involving surgery for a retarded person's congenital heart defect); *In re* Hofbauer, 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979) (involving radiation and chemotherapy for treatment of Hodgkin's disease); *In re* Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955) (involving surgery to correct a hairlip and a cleft palate); *In re* Green, 220 Pa. Super. 191, 286 A.2d 681 (1971) (involving surgery to correct spinal curvature); *In re* Tuttendario, 21 Pa. D. 561 (1912) (involving surgery to prevent crippling by rickets); *In re* Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942) (involving amputation of grossly enlarged and useless arm).

202. To dispel skepticism regarding the realistic possibility of such advanced medical procedures, see Rhoden, *The New Neonatal Dilemma: Live Births from Late Abortions*, 72 GEO. L.J. 1451 (1984); Scott, *Test Tube Babies, Experimental Medicine and Allied Problems*, 58 AUSTRALIAN L.J. 405 (1984).

length in *Roe v. Wade*.[203] However, the heuristic value of this now hypothetical problem should not be ignored. The problem is illustrative of the fate of individual privacy rights in the face of medical progress, which continues to reduce infant mortality rates.[204]

Courts will eventually be called upon to decide among countervailing constitutional rights in these and other similar areas. How can such cases be decided without inflicting unconscionable results on one class or another?[205] The issue of court-ordered medical treatment in the context of countervailing constitutional rights has been addressed by state courts, but has been almost entirely limited to religious objections raised by parents.[206] In determining, for example, whether to compel medical treatment over religious objections, courts have usually favored the constitutional rights of the patient where it was the patient's own religious preferences being challenged.[207] Where the parents' or guardian's religious preferences have resulted in nontreatment of a minor, for example, the states have favored treatment for the child under its police powers and its interests in guarding against child neglect and abuse.[208]

The question has yet to be addressed, however, of whether a mother's right to privacy would prevail over her embryo's right to life (stemming from the state's interest in preempting a needless destruction) where the mother seeks, and qualifies for, an abortion

---

203. 410 U.S. 113, 163-65 (1973). After the fetus becomes viable, which happens during the second trimester of pregnancy, the state's interest in preserving the potentiality of human life becomes compelling, permitting the state to regulate abortions. *Id.*

204. At the time of this writing, a physician is under investigation for implanting a nonapproved artificial heart during emergency surgery into a patient who had not consented to the implantation. *See* N.Y. Times, Mar. 8, 1985, § 1, at 1, col. 1.

205. Of course, only one of the two opposite interests can ultimately prevail in deciding whether to continue life-sustaining medical treatment.

206. Where the federal constitutional right is not relevant, the state's strong interest in protecting the sanctity of human life still makes the newborn's interests paramount to all others. *See Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225 (recognizing the California constitutional right to privacy); *In re* Guardianship of Roe, 383 Mass. 415, 421 N.E.2d 40 (1981) (relying on state common law in upholding an individual's right to decide whether to receive potentially dangerous medical treatment). *Quinlan*, 70 N.J. at 40, 355 A.2d at 633 (recognizing the New Jersey constitutional right to privacy). For a statute enunciating legislative policy protecting critically ill or defective newborns, see LA. REV. STAT. ANN. § 40:1299.36.1 (West Supp. 1985), said to be the first state law of its kind. *See also* CAL. HEALTH & SAFETY CODE § 275 (West Supp. 1985).

207. *See, e.g.*, Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978); *In re* Yetter, 62 Pa. D. & C. 619 (1973). *But cf. In re* President and Directors of Georgetown College, 331 F.2d 100 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971).

208. Abandoning medical treatment of newborns is said to undermine statutes on homicide, child abuse, child neglect, and child abuse reporting. *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 275, 286(b) (West Supp. 1985) (promoting health care for critically ill newborns).

under *Roe v. Wade*.[209] Were a court to decide this delicate social issue under currently prevailing law, it would not only be able, but indeed behooved, to find for the embryo and the state. Under current law, the consensus is that no right to die exists for the embryo[210] where the intrusion is minimal, the treatment (in this case, *in vitro* rearing) involves no pain or suffering, and the embryo's life will be preserved rather than merely prolonged.[211] The mother's right to privacy would not be invaded under this analysis because the physical intrusion is lesser than or equal to the intrusion required for the clinical abortion she seeks.

If advanced medical procedures enable the removal and rearing of an embryo in this manner, a woman's presently defined right to privacy regarding abortion decisions may be rendered moot.[212] The privacy right set forth in *Roe v. Wade* addressed privacy rights encompassing a "decision whether or not to terminate her pregnancy."[213] If the state were to effectuate removal of the embryo for

209. For example, the mother may receive an abortion in the first trimester of pregnancy. *See Roe*, 410 U.S. at 163.

210. Assuming *arguendo* that the embryo would be entitled to constitutional protection, it would properly be subject to a right-to-die analysis. *Roe*, however, held that an embryo in the first trimester of human prenatal development is not yet entitled to any constitutional protection that would undermine the mother's privacy rights. *Roe*, 410 U.S. at 163-65. "[T]he word 'person,' as used in the Fourteenth Amendment, does not include the unborn." *Id.* at 158. Viability is the yardstick for affording legal rights and protection to the unborn. *Id.* at 161-62. However, the state has another important and legitimate interest—protecting the potentiality of human life. *Id.* at 162. It would seem, then, that the embryo in our hypothetical is viable and thus entitled to protection under *Roe*. Applying a strict *Roe* analysis, the mother's privacy rights become subordinate to the state's interest in preserving potential life where the embryo is capable of survival outside the womb.

211. *See supra* notes 165-79 and accompanying text.

212. The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. . . . [T]he additional difficulties and continuing stigma of unwed motherhood may be involved.

Roe, 410 U.S. at 153. If the removal procedures proposed by the state eliminate the detriments recognized by the *Roe* court, can it be said that women still have privacy rights sufficient to overcome state regulation in this area? The answer to this query depends on whether the law seeks to protect women from the incidents of unwanted motherhood or whether there is a sublime privacy right which cannot be abridged absent compelling circumstances.

213. *Id.*

rearing *in vitro*, the mother's pregnancy is nonetheless terminated. The question arising is whether the state can legally compel the mother to instead submit to the removal procedure.[214] The resulting child would probably become a ward of the state because *Roe* protects the mother from other incidents of pregnancy, such as invasions of privacy, which accompany the compelled rearing of her unwanted child.[215]

After considering all of the legal contortions, reflect for a moment on what has been accomplished in furthering the state interest in preserving life, notwithstanding the conflicting privacy rights of the mother and the embryo: 1) a woman who desires a legal abortion has been compelled to submit to the removal of her embryo for rearing *in vitro;* 2) a ward of the state has been created; 3) a child alive but not presently viable has been either raised in a laboratory environment, released to surrogate parents for implantation, or institutionalized until such time as adoptive parents take over; and 4) a legally competent woman has been forced to submit to medical treatment without her consent and deliver up her offspring to the government against her contrary wishes.

The woman, of course, had a choice—she could have elected to abandon termination efforts and thus avoid the state-ordered removal. So what has happened to her right of privacy, her right to bodily integrity, and her liberty interest, assured by *Roe*, regarding "activities relating to marriage, . . . procreation, . . . contraception, . . . family relationships, . . . and child rearing and education . . ."?[216] This is to say nothing of the privacy rights of the embryo. To what risks of deformity, underdevelopment, and future emotional or psychological mishaps is the child subjected by such a process?

VII. CONCLUSION

The problems with administering such a controversial and socially repugnant right do not stem merely from balancing the interests which inherently compete with its administration. Equally vexing difficulties are encountered in simply delineating what those interests are and in ascertaining how they weigh against one another. In other words, difficulties arise not only in formulating appropriate

214. It seems that the only existing legal vehicle for expectant mothers opposing the removal procedure in this case would be that of a cause of action for battery. One court has stated: "A long line of cases, . . . have held that where a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this principle is that a competent adult patient has the legal right to refuse medical treatment." *Barber*, 147 Cal. App. 3d at 1015, 195 Cal. Rptr. at 489; *see also Bartling*, 163 Cal. App. 3d at 194, 209 Cal. Rptr. at 224.

215. *See supra* note 212.

216. *Roe*, 410 U.S. at 152-53.

equations which balance the competing interests, but also in assigning satisfactory values to the constants and variables contained therein.

Even if we do formulate acceptable equations which aid us in assessing competing interests, these equations must be adaptable to changing times and changing circumstances. The determination to be made is no longer one of rote balancing, weighed blindly in the venerable tradition on Athena's scales of justice. Courts, philosophers, theologians, and laymen would disagree as to the respective weights assigned to the equation's variables. But while medical science has progressed by leaps and bounds, affecting human life and destiny in exponential dimensions, our courts and legislatures have mostly lagged behind in this sensitive area, still tinkering with concepts of law and medicine which date back to the fourth century B.C. While scientists split atoms and measure their diameters with electronic equipment to within a hundredth of an angstrom, it seems that lawmakers muddle in the distance, trying to make similar measurements in cubits.

The point being made is that times have changed. Life as we know it has changed. Death, as defined by law and medicine, has changed. Our law must keep abreast of these changes if it is to have any meaning and effect in such a socially volatile area.

Amidst all of the doubt involving right-to-die issues, one thing is certain: privacy rights are sure to become extinct unless the laws governing the right to refuse medical treatment are overhauled to reflect the realities of current medical practice. Courts which have dealt with these sensitive issues have always relied on the notion of bodily intrusion when weighing the patient's case for removal; thus, the courts have afforded protection from only physical invasions. The unfortunate result of this focus is that one's privacy includes profoundly more than freedom from *physical* invasion, especially where medical treatment becomes progressively less physical by the day. In short, if individual privacy is what we seek to protect, we must embrace more than the mere physical implications of compelled treatment.

GLENN W. PETERSON