Washington and Lee Law Review

Volume 34 | Issue 1 Article 15

Winter 1-1-1977

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IN RE QUINLAN: ONE COURT'S ANSWER TO THE PROBLEM OF DEATH WITH DIGNITY

On the night of April 15, 1975, Karen Ann Quinlan, aged 22, lapsed into a coma from which she still has not emerged.[1] On September 10, 1975, her father applied to the Chancery division of the Superior Court of New Jersey for letters of guardianship with the express power to authorize "the discontinuance of all extraordinary means of sustaining the vital processes of his daughter. . . ."[2] This request was strenuously opposed by Karen's doctors, the hospital in which she was being treated, the county prosecutor, Karen's guardian ad litem, and the state of New Jersey, which had intervened on the basis of a state interest in the preservation of life.[3]

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[1] Bergen County Record, Nov. 5, 1976, at A-1, col. 3.

[2] 1 IN THE MATTER OF KAREN QUINLAN 3 (1975). A subsequent amendment to the complaint sought to restrain Karen's attending physicians and her hospital from interfering with any such exercise of authority and to enjoin any criminal prosecution against any party should Karen's death result. *Id.* at 14. For a compilation of all of the trial court proceedings, transcripts, affidavits, briefs, and decision of *In re* Quinlan, see 1 IN THE MATTER OF KAREN QUINLAN (1975). For a similar compilation of the supreme court proceedings, see 2 IN THE MATTER OF KAREN QUINLAN (1976).

[3] On appeal, the state supreme court upheld the state's right to intervene, citing the Declaration of Independence, the United States Constitution, and the New Jersey Constitution for the proposition that the state's interest in life has "an undoubted constitutional foundation." *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, 652 (1976). The state constitution provides for state protection of "certain natural and unalienable rights, among which are those of enjoying and defending life. . . ." N.J. CONST. art. I, par. 1.

Apart from the specific New Jersey constitutional provision, the right of a state as parens patriae to intervene for the purpose of preserving or protecting life appears to be well settled. The intervention usually is justified on the ground that the state has a special duty both to represent society's concern for human life and to help an incompetent or otherwise disabled person to make a vital decision concerning his welfare. *In re* Weberlist, 79 Misc.2d 753, 360 N.Y.S.2d 783 (Sup. Ct. 1974). In Roe v. Wade, 410 U.S. 113, 155 (1973), the Supreme Court held that the state interest as to protection of health, medical standards, and prenatal life was legitimate and sufficient to limit the right of a woman to receive an abortion. *See generally* Note, *Compulsory Medical Treatment: The State's Interest Reevaluated,* 51 MINN. L. REV. 293 (1966). Statutes requiring motorcyclists to wear crash helmets are examples of legislation promoting this state interest. *E.g.,* CONN. GEN. STAT. ANN. § 14-289(e)(West 1970). There is, however, a split in authority as to the constitutionality of these laws. *See* Annot., 32 A.L.R.3d 1270 (1970). For other instances of the assertion of the state's interest in protecting life, see Lawson v. Commonwealth, 291 Ky. 437, 164 S.W.2d 972 (1942) (state statute forbidding use of handling of snakes in religious rituals upheld); Byrn, *Compulsory Lifesaving Treatment for the Competent Adult,* 44 FORD. L. REV. 1, 7 (1975) [hereinafter cited as Byrn].

The trial court found that Karen's coma was the result of anoxia[4] and subsequent decortication[5] which left the patient in a chronic and persistent vegetative state[6] and totally dependent upon a mechanical respirator for breathing.[7] Nonetheless, the trial court denied the plaintiff's application.[8] On appeal, the Supreme Court of New Jersey unanimously reversed, holding that Karen was not legally or medically dead[9] and that her constitutional right of privacy[10] was broad

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[4] "Anoxia" is defined as "[d]ecreased amount of oxygen in organs and tissues, *i.e.*, less than the physiologically normal amount. . . ." STEDMAN'S MEDICAL DICTIONARY 77 (22d Ed. 1972). Karen had ceased breathing for at least two 15-minute periods before receiving aid. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, 654 (1976).

[5] Cerebral decortication is total or partial destruction of an external layer of brain tissue on the surface of the cerebral hemisphere, usually brought about by anoxia. STEDMAN'S MEDICAL DICTIONARY 326 (22d Ed. 1972).

[6] A patient in a chronic and persistent vegetative state was defined by an expert medical witness at trial as a "subject who remains with the capacity to maintain the vegetative parts of neurological function but who. . .no longer has any cognitive function." Karen experienced no awareness of her environment, and had a fetal-like posture with extreme flexion-rigidity of her muscles. She was able only to move, grimace, and make stereotyped sounds. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, 654-655 (1976).

[7] At the time of trial, the testifying physicians believed that Karen could not survive without assistance of the respirator and that if it was removed death would soon follow. *Id.* at 655. Karen has been transferred from the intensive care unit at the hospital to the New Jersey state rest home, and since May 22, 1976 has been breathing without the aid of a respirator. Bergen County Record, Nov. 5, 1976, at A-1, col. 3.

[8] *In re* Quinlan, 137 N.J. Super. 227, 269-70, 348 A.2d 801, 824 (Ch. 1975).

[9] The trial court's pretrial order contained a "factual and legal contention" by the plaintiff that under New Jersey law, Karen was legally dead. At trial, this contention was discarded by a stipulated amendment to the order to the effect that Karen was alive. The supreme court found this amendment to be supported by medical evidence, and affirmed the trial court's refusal to grant a request by Karen's hospital to determine whether the use of criteria developed by the Ad Hoc Committee of Harvard Medical School to determine when a patient is dead is in accordance with standard medical practice. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, 652-3 (1976). Although the court dismissed the request as not ripe for adjudication, it nevertheless applied the Ad Hoc standards to determine that Karen was not brain dead. The four main standards are: unreceptivity and unresponsitivity to applied stimuli, no spontaneous respiration or movements, no elicitable reflexes, and a "flat" electroencephalogram. These tests are conducted twice, the second repeated at least 24 hours after the first. To be conclusive, the results of both tests must be the same. If all test responses are negative, the Ad Hoc Committee recommends that, upon decision of the attending physician, "[d]eath is to be declared and *then* the respirator turned off." *Report of the Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death: A Definition of "Irreversible Coma,"* 205 J.A.M.A. 337, 338 (1968). *See generally* Charron, *Death: A Philosophical Perspective on the Legal Definitions,* 1975 WASH. U.L.Q. 979; H. van Till- d'Aulnis de Bourouill, *Diagnosis of Death in Comatose Patients under Resuscitation Treatment: A Critical Review of the Harvard Report,* 2 AM. J. OF L. AND MED. 1 (1976).

Although the supreme court did not hold that Karen was brain dead, it indicated that her condition offered almost no hope for recovery:

enough to encompass a decision to decline medical treatment in the face of overwhelming medical evidence establishing an extreme unlikelihood that she will return to a cognitive or sapient existence.[11] The court also held that because Karen's incompetency prevented her conscious exercise of this right, her guardian would be allowed, based on his best judgment as to how she would exercise her right under the circumstances, to decide whether the life-sustaining procedures should be removed. In addition to this substantial expansion and delineation of the right of privacy, the *Quinlan* decision redefined the spheres of judicial and medical responsibility in situations relating to the sustainment of life by artificial means.[12]

The plaintiff presented three theories upon which a decision to grant his request to remove Karen's life-support apparatus could be based. First, he urged that the right of privacy included the right of an individual to refuse "to submit to medical treatment which offers

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> No form of treatment which can cure or improve that condition is known or available. As nearly as may be determined, considering the guarded area of remote uncertainties characteristic of most medical science predictions, she can *never* be restored to cognitive or sapient life.

In re Quinlan, 70 N.J. 10, 355 A.2d 647, 655 (1976). For a definition of the terms cognitive or sapient, see note 11 *infra*.

[10] For treatment of the development of the right of privacy, see Forkosch, *Privacy, Human Dignity, Euthanasia—Are These Independent Constitutional Rights?*, 3 U. SAN FERN. L. REV. 1 (No. 2 1974); Fried, *Privacy*, 77 YALE L.J. 475 (1968); Hufstedler, *The Directions and Misdirections of a Constitutional Right of Privacy*, 26 THE REC. OF THE A. OF THE B. OF THE CITY OF N.Y. 546 (1971).

[11] *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, 671 (1976). The terms "cognitive or sapient" are not medical but psychological, and refer to the ability of human beings to behave purposefully in response to perceived and remembered environmental demands. 2 IN THE MATTER OF KAREN QUINLAN at p. xi (1976) (introduction by D. R. Robinson).

[12] The sheer volume of prior medical and legal literature relating to euthanasia, compulsory lifesaving treatment, and the prolonging of life by artificial means necessitates restriction of the scope of this comment to a specific analysis of the *Quinlan* case itself, without extended theoretical discussion of the problem in general. For a broad overview, see A. DOWNING, EUTHANASIA AND THE RIGHT TO DEATH (1969); O. RUSSELL, FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA (1975); S. SHINDELL, THE LAW IN MEDICAL PRACTICE (1966); G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW (1957); Byrn, *supra* note 3; Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus The Preservation of Life*, 26 RUTGERS L. REV. 228 (1973) [hereinafter cited as Cantor]; Delgado, *Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474 (1975) [hereinafter cited as Delgado]; Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958); Sharpe & Hargest, *Lifesaving Treatment for Unwilling Patients*, 36 FORD L. REV. 695 (1968); Comment, *The Right to Die*, 10 CALIF. WEST. L. REV. 613 (1974). This listing is not comprehensive.

no hope of relief or cure."[13] The plaintiff argued that such a right belonged to the class of personal freedoms first given protection by the United States Supreme Court in *Union Pacific Railway v. Botsford*[14] and more recently characterized in *Griswold v.*

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[13] Brief for Appellant, 2 IN THE MATTER OF KAREN QUINLAN 1, 16 (1976) [hereinafter cited as Brief for Appellant].

[14] 141 U.S. 250 (1891). In *Botsford,* the defendant had brought a personal injury action against the railroad, which then had sought an order compelling her to undergo a physical examination in advance of trial. In affirming the lower court's refusal to issue the order, the Court said that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Id.* at 251. While physical examination of parties in actions in federal courts is now generally allowed under FED. R. CIV. P. 35, this fact should not alter the applicability of the *Botsford* rationale to cases involving the refusal to accept medical care.

Botsford did not rely on any constitutional base. Rather, it elucidated a common law right of bodily self-determination that allows every person ultimate control over his body. This right is invoked most commonly in tort cases granting relief to patients on whom medical personnel have operated against their wishes. The most famous of these is Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914), where former Judge Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Id.* at 93. *See also* Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (1960); Pearl v. Lesnick, 20 App. Div.2d 761, 247 N.Y.S.2d 561 (1st Dept. 1964), *aff'd,* 19 N.Y.2d 590, 224 N.E.2d 739, 278 N.Y.S.2d 237 (1967); Annot., 56 A.L.R. 2d 695 (1957). The patient's right of bodily determination also finds expression in the doctrine of informed consent. Under this doctrine, a physician has an affirmative duty to warn the patient of all material risks attendant upon a proposed course of treatment so that the patient may make an informed decision to submit to or forego the treatment. *See* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972); Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970); Cantor, *supra* note 12, at 237; Plante, *An Analysis of "Informed Consent",* 36 FORD. L. REV. 639 (1968).

In Roe v. Wade, 410 U.S. 113 (1973), the Supreme Court indicated that the right of bodily self-determination is distinct from the right of privacy, and subject to legitimate state limitation:

> [I]t is not clear to us that the claim asserted by some *amici* that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions. The Court has refused to recognize an unlimited right of this kind in the past.

Id. at 154 (citations omitted). The Supreme Court cited Buck v. Bell, 274 U.S. 200 (1927) (state statute providing for the sexual sterilization of inmates of state institutions who are afflicted with hereditary insanity or imbecility upheld) and Jacobson v. Massachusetts, 197 U.S. 11 (1905) (state statute providing for compulsory smallpox vaccination of adults in accordance with city ordinances not violative of fourteenth amendment) in support of this statement. *See* Byrn, *supra* note 3 at 6 n.31. The plaintiff in *In re* Quinlan made no separate argument based on this common law right

Connecticut[15] as "penumbral" to the first, fourth, fifth, ninth, and fourteenth amendments.

Second, the plaintiff argued that since the decision to seek authorization to remove Karen from the respirator was reached only after months of prayer and counseling, it represented "a cooperation in carrying out the Lord's will."[16] As such, it constituted a free exercise of the plaintiff's religious beliefs and was protected by the establishment clause of the first amendment.[17] In support of this argument, the plaintiff cited a papal *allocutio*[18] for the proposition that his request was neither prohibited by nor offensive to the tenets of his family's faith, Roman Catholicism. Finally, Mr. Quinlan maintained that to require Karen to be kept alive by extraordinary means "after the dignity, beauty, promise, and meaning of earthly life have vanished"[19] subjected Karen and her family to cruel and unusual punishment in violation of the eighth amendment.[20]

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of bodily self-determination, and the state supreme court did not distinguish it from the asserted right of privacy. One must conclude that the court thought the two rights substantially identical because counsel for plaintiff urged that "[i]t does not appear necessary in the present circumstances to make a distinction between the right of privacy and the right of self-determination." Brief for Appellant, *supra* note 13 at 13 n.3.

[15] 381 U.S. 479 (1965). In *Griswold*, the Court invalidated a Connecticut statute prohibiting use of contraceptives by married couples and distribution of birth control information and devices to them. Writing for the Court, Justice Douglas stated that certain amendments have penumbras encompassing zones of privacy that are protected against governmental invasions. Only rights which are "fundamental" or "implicit in the concept of ordered liberty," however, are included within the penumbras of personal privacy. *Cf.* Palko v. Connecticut, 302 U.S. 319, 325 (1937) (where Justice Cardozo formulated the "implicit in the concept of ordered liberty" doctrine). The *Griswold* Court held that the right to marital privacy is but another in a long line of personal penumbral rights which have enjoyed judicial vindication. *See* Roe v. Wade, 410 U.S. 113 (1973) (abortion); Eisenstadt v. Baird, 405 U.S. 438 (1972) (contraception); Katz v. United States, 389 U.S. 347 (1967) (communication); Loving v. Virginia, 388 U.S. 1 (1967) (family relationships); Skinner v. Oklahoma, 316 U.S. 535 (1942) (procreation); Pierce v. Society of Sisters, 268 U.S. 510 (1925) and Meyer v. Nebraska, 262 U.S. 390 (1923) (child rearing and education).

[16] Brief for Appellant, *supra* note 13, at 23.

[17] The first amendment reads in part that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof. . . ." U.S. CONST. amend. I. This amendment was held applicable to the states through the fourteenth amendment in Cantwell v. Connecticut, 310 U.S. 296, 303 (1940).

[18] Pope Pius XII, *The Prolongation of Life*, 4 POPE SPEAKS 393 (1958). An *allocutio* is an address given by the Pope and regarded as expositive of the official position of the Church on a given issue.

[19] Brief for Appellant, *supra* note 13, at 27.

[20] The eighth amendment provides that "[e]xcessive bail shall not be required,

The New Jersey Supreme Court agreed with the reasoning of the trial court and summarily rejected the "free exercise of religion" and "cruel and unusual punishment" arguments. With respect to the former, the court concurred in the trial court's interpretation of the papal *allocutio*[21] as an essentially neutral proclamation that "it is neither a mortal sin to continue nor discontinue 'extraordinary' means of support for the body functions."[22] The supreme court reasoned that the impingement on religious beliefs or religious neutrality in the face of the state's interest in the preservation of life did not reflect a constitutional question,[23] and that it would not recognize an independent parental right of religious freedom to support the relief requested.[24]

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nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. CONST., amend. VIII.

[21] The *allocutio* concludes that "if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply." Brief for Appellant, *supra* note 13, at 25.

[22] 137 N.J. Super. at 267, 348 A.2d at 823.

[23] While the right to religious beliefs is absolute, actions in pursuance of those beliefs are subject to regulation in furtherance of a legitimate state interest. Cantwell v. Connecticut, 310 U.S. 296 (1940); Zucht v. King, 260 U.S. 174 (1922); Reynolds v. United States, 98 U.S. 145 (1879). However, these interests must be of a compelling and paramount nature before curtailment of religious liberty is allowed. Wisconsin v. Yoder, 406 U.S. 205, 213-14 (1972); Sherbert v. Verner, 374 U.S. 398, 406 (1963); West Va. Bd. of Educ. v. Barnette, 319 U.S. 624, 639 (1943).

Such state interests are commonly found in cases where courts have ordered blood transfusions for Jehovah's Witnesses, whose religious beliefs preclude them from consenting to such treatment. *See* Annot., 9 A.L.R.2d 1391 (1966); Byrn, *supra* note 3; Cantor, *supra* note 12; Ford, *Refusal of Blood Transfusions by Jehovah's Witnesses*, 10 CATHOLIC LAW. 212 (1964). Compelling interests include the safeguarding of the life of a minor despite parental objection to treatment, People *ex rel.* Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769, *cert. denied*, 344 U.S. 824 (1952); State v. Perricone, 37 N.J. 463, 181 A.2d 751, *cert. denied*, 371 U.S. 890 (1962); the treating of a parent to protect the interests of a minor dependent, Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); the protection of an unborn child, Raleigh Fitkin—Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964); respect for the physician's conscience and professional oath, United States v. George, 239 F. Supp. 752 (D.C. Conn. 1965), *but see* Byrn *supra* note 3, at 29; and the state's general interest in the preservation of life, John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1970); *see* note 3 *supra*. These interests may also justify an infringement of the right of privacy. Roe v. Wade, 410 U.S. 113 (1973). Mr. Quinlan argued that no such state interests were present in the case of his daughter.

[24] 355 A.2d at 661-62. With regard to the independent parental claim of religious belief, the trial court noted that parental standing to assert a constitutional claim

In response to the plaintiff's eighth amendment argument,[25] the supreme court held that the cruel and unusual punishment clause did not apply in the absence of the imposition of penal sanctions.[26] The court acknowledged that Karen was indeed subjected to cruel and unusual conditions, but that since neither the state nor the law was responsible for inflicting such conditions, the requisite element of punishment was lacking.[27]

The supreme court, however, accepted the plaintiff's argument that Karen's right of privacy included the right to die, thereby reversing the holding of the lower court.[28] Chief Justice Hughes reasoned that this was a right within the penumbral rights defined by the Supreme Court in *Griswold,*[29] and analogized it to a woman's limited right to receive an abortion.[30] The court stated that "[p]resumably [the right of privacy] is broad enough to encompass a patient's

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relating to actions of children previously had been upheld only in instances dealing with the future life conduct of the children. 137 N.J. Super. at 267, 348 A.2d at 823. *See* Wisconsin v. Yoder, 406 U.S. 205 (1972) (claim that application of state compulsory school-attendance law to Amish children violated parents' first amendment rights upheld); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (state statute compelling children to attend public schools held violative of parents' right under fourteenth amendment to direct the upbringing of their children). Since the parental claim in *Quinlan* dealt with the ending of a child's life, and not the upbringing of the child, the trial court declined to apply the *Yoder* and *Pierce* rationale to the situation before it.

[25] The plaintiff cited Justice Brennan's statement in his concurring opinion in Furman v. Georgia, 408 U.S. 238, 270 (1972), that "punishment is 'cruel and unusual' if it does not comport with human dignity." The plaintiff contended that a constitutional violation of the right could be found even in the absence of a state-imposed criminal sanction. Brief for Appellant, *supra* note 13, at 26-27.

[26] 355 A.2d at 662.

[27] The supreme court's holding that the eighth amendment does not apply in the absence of a penal sanction is well supported. *See* Furman v. Georgia, 408 U.S. 238 (1972); Trop v. Dulles, 356 U.S. 86 (1957); Granucci, *"Nor Cruel and Unusual Punishments Inflicted": The Original Meaning,* 57 CALIF. L. REV. 839 (1969).

[28] The trial court rejected the plaintiff's privacy claim on two grounds. First, it stated that since none of the right-of-privacy cases involved a claim which, if granted, would lead to the individual's death, the compelling state interest found lacking in those cases was present in the instant case in the form of the state's interest in preserving life. 137 N.J. Super. at 265, 348 A.2d at 822; *see* note 3 *supra.* Second, the court held that the right of the patient could not be exercised by the parents, and noted that the only cases in which such derivative exercises of a child's constitutional rights were upheld were those involving "continuing life styles." 137 N.J. Super. at 266, 348 A.2d at 822; *see* Wisconsin v. Yoder, 400 U.S. 205 (1972); Pierce v. Society of Sisters, 268 U.S. 510 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923).

[29] *See* note 15 *supra.*

[30] Roe v. Wade, 410 U.S. 113 (1973).

decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."[31]

This analogy is not without foundation, since many of the same arguments that support a right to terminate a pregnancy support an individual's right to reject life-prolonging medical treatment. Both are highly personal decisions that involve a physician's judgment and advice. The possibilities of enormous financial expense, severe mental or physical distress, and the violation of deeply felt ethical and religious beliefs are attendant to both situations, at least when the patient is not comatose.[32] Finally and most importantly, the end result of both decisions is the death of a human being or a potentially living fetus.[33] Underlying these similarities are larger considerations of social policy which accompany both abortion and euthanasia.[34]

In defining the "right to die", the *Quinlan* court balanced the state's interest in preserving life against Karen's right of privacy.[35] The court reasoned that an individual has a right to be free from bodily invasion even if the intrusion is necessary to keep the patient alive, unless the state's interest in preserving life can be said to be superior to the individual's asserted claim of privacy. This depends upon the likelihood of the patient recovering from his illness; if the medical prognosis admits of no chance of recovery, the state's interest is not compelling and will not outweigh the patient's right to refuse

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[31] 355 A.2d at 663.

[32] This analysis assumes that the patient is capable of feeling such distress. In the case of a comatose subject such as Karen, no argument can be advanced that she felt any distress or experienced any violation of her beliefs. This may account for the court not discussing these specific factors in its opinion, although they remain important in analyzing the general relationships between the right to abortion and the right to have life-sustaining treatment removed.

[33] *See* Roe v. Wade, 410 U.S. 113, 150 (1973), where the Court stated that the state may assert its protective interest even when only potential life, in the form of a fetus, is involved.

[34] *See* Delgado, *supra* note 12, at 479. The issues of population growth and poverty will come into play when a limited right to die is recognized. In light of the scarce and expensive nature of medical facilities, the need to utilize costly hospital equipment and space misallocates resources. Finally, an individual might choose to leave his personal financial assets to his heirs and loved ones rather than deplete his funds in paying doctors, hospitals, and other medical costs.

[35] In Roe v. Wade, 410 U.S. 113, 154 (1973), the Court noted that since the state may properly assert interests in safeguarding health, maintaining medical standards, and protecting life, the right of privacy is not absolute. *See also* Eisenstadt v. Baird, 405 U.S. 438, 453 (1972). Therefore, the limited nature of the right of privacy necessitates a balancing of the legitimate state interests involved against the nature of the right asserted by the individual.

or have withdrawn life-prolonging treatment.[36] The court stated that "the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's right overcomes the State interest."[37]

Since Karen's prognosis was extremely poor and the degree of bodily invasion, consisting of the respirator, intravenous feeding, and antibiotics, was very great,[38] the court concluded that the state's interest was subordinated to her constitutional right.[39] Chief Justice Hughes distinguished the blood transfusion cases where the patient was not allowed to reject treatment on the ground that "the medical

[36] The test applied in Roe v. Wade, 410 U.S. 113 (1973), to determine when a mother may terminate the life of a fetus is similar to the test applied in *Quinlan* to determine when a patient may refuse life-prolonging treatment. Both tests attempt to define a point at which the state's interest becomes compelling, thereby barring exercise of the individual's right of privacy. In *Wade*, the Court held that the state has a compelling interest in preventing abortions when the fetus is viable and capable of meaningful life outside of the mother. Similarly, the *Quinlan* court held that the patient may not exercise his right to terminate care if there is a reasonable hope of recovery. Since in both situations the state's interest is compelling when the fetus or individual becomes capable of meaningful life, the two tests employ the same analysis, and *Wade* supports the approach taken in *Quinlan*. *See* Note, *The Tragic Choice: Termination of Care For Patients in a Permanent Vegetative State*, 51 N.Y.U. L. Rev. 285, 291-92 (1976).

[37] 355 A.2d at 664. This analysis would seem sufficient to classify the state's interest in preserving life as controlling in the context of an argument based on religious freedom, but not when the right of privacy is involved. In the latter case, the type of invasion is tangible and physically intrusive upon the specific entity which is to be protected—the human body. Such immediacy and acuity of bodily invasion is not present when religious beliefs are offended. In qualitative terms, however, the intrusion may be viewed as equally onerous.

[38] The Attorney General of New Jersey has stated that the court's decision could allow for the withdrawal of the artificial feeding apparatuses and antibiotic medication that Karen is currently receiving, and does not apply only to the mechanical respirator which was specified at trial as the prime life support. N.Y. Post, June 19, 1976, at 10, col. 3. Since the court's holding authorized withdrawal of the "present life support system," *see* text accompanying note 94 *infra*, intravenous feeding devices and certain drugs could conceivably be included within the scope of the authorization. *Cf.* W. NOLEN, A SURGEON'S WORLD 279-80 (1972), where the author, a surgeon, stated: "Discontinuing the intravenous feedings and antibiotics, taking away the supports we use to prop up a life, is one thing; doing something to shorten a life is quite another." (quoted in Byrn *supra* note 3, at 28 n.129). Given that the components of a "life support system" are defined by standard medical practice, presumably the treating and attending physicians in the *Quinlan* case will make any final decision as to the extent of the court's authorization subject to approval by an Ethics Committee. *See* text accompanying note 88 *infra*.

[39] 355 A.2d at 664.

procedure required. . .constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good."[40]

Although *Quinlan* is the first case to hold that the right of privacy includes the specific right to decline or withdraw vital life-support treatment, the New Jersey Supreme Court's decision is not without some precedent. Other cases have recognized that an individual is entitled to decide whether he is to receive medical treatment, even if his refusal to submit to such treatment would lead to his death.

In re Yetter[41] concerned a 60 year old female inmate of a state mental institution who refused to submit to a surgical biopsy to determine whether she was afflicted with breast cancer. Without the surgical procedures, death was likely but not imminent. The inmate's brother petitioned for appointment as her guardian for the purpose of consenting to the surgery, but the court refused to overrule the patient's decision to forego treatment. Although Mrs. Yetter was suffering from delusions about the problem, the Pennsylvania court found her decision to be competently made, and held that "[t]he right of privacy includes the 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."[42] While the *Quinlan* court did not apply a "clear and present danger" test, the *Yetter* court's formulation of the right of privacy as encompassing the right to die clearly presaged the constitutional analysis employed by the New Jersey Supreme Court.

In *In re Osborne*[43] the court refused to compel blood transfusions to a Jehovah's Witness who had competently declined to consent to them. Although the decision was based on the patient's claim of free exercise of religion,[44] a concurring judge noted that he thought the

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[40] *Id.*

[41] 62 Pa. D. & C. 2d 619 (C. P. Northampton County Ct. 1973).

[42] *Id.* at 623 (emphasis added). A Jehovah's Witnesses' blood transfusion case, *In re* Estate of Brooks, 32 Ill.2d 361, 205 N.E.2d 435 (1965), has been criticized for its similar use of "a clear and present danger" test instead of the "compelling state interest" test. 44 TEXAS L. REV. 190, 192-193 (1965). *Yetter* has been criticized for employing a right of privacy rationale instead of the common law right of bodily self-determination. *See* Byrn, *supra* note 3, at 5-10. *See* note 14 *supra* for a discussion of the right of bodily self-determination.

[43] 294 A.2d 372 (D.C. Ct. App. 1972).

[44] *Id.* at 375. The majority opinion rejected the argument accepted in *Quinlan* that the state must have a compelling interest in sustaining life, stating that "[t]he notion that the individual exists for the good of the state is, of course, quite antithetical to our fundamental thesis that the role of the state is to ensure a maximum of individual freedom of choice and conduct." *Id.* at n.5.

opinion was grounded not only in religious freedom but also on a broader based "freedom of choice."[45] As in *Quinlan,* the concurring opinion did not differentiate between the right of privacy and the right of bodily self-determination, nor did it indicate that either right alone formed the basis of the theory of "freedom of choice."

In *Palm Springs General Hospital, Inc. v. Martinez,*[46] a 72 year old, terminally anemic woman refused to undergo surgery which would have prolonged her life but offered no hope of a cure. When her physician sought guidance as to his possible liability should he allow the patient to die, the Florida court refused to compel Mrs. Martinez to submit to the surgery. The patient made no objections based on religion, and the court framed its narrow holding in terms of a right to refuse medical treatment:

> Based upon [her] debilitated physical condition. . .and the fact that performance of surgery. . .would only result in the painful extension of her life for a short period of time, it is not in the interest of justice for this Court of Equity to order that she be kept alive against her will. A conscious adult patient who is mentally competent has the right to refuse medical treatment, even when the best medical opinion deems it essential to save her life.[47]

Martinez might be distinguished from the present case in that the relative ages of Mrs. Martinez and Karen Quinlan provide a stronger policy consideration towards allowing a very old woman to refuse life-prolonging treatment while not granting the same relief to a younger one. However, the *Martinez* court's reliance on the patient's poor physical condition and slight chance of recovery indicate that the standard for granting relief closely resembled that employed in *Quinlan.* Nevertheless, a distinction as to age should not be determinative if the younger patient's medical prognosis is equally as dim, as it was in *Quinlan.*

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[45] *Id.* at 376 (Yeagley, J., concurring).

[46] Civ. No. 71-12687 (Dade County Cir. Ct., filed July 2, 1971). The *Martinez* case is discussed in Byrn, *supra* note 3, at 13-14.

[47] Palm Springs Gen. Hosp., Inc. v. Martinez, Civ. No. 71-12687 (Dade County Cir. Ct., filed July 2, 1971). *Accord, In re* Raasch, No. 455-996 (Milwaukee County Ct., filed Jan. 25, 1972), *discussed in* Sullivan, *The Dying Person—His Plight and His Right,* 8 NEW ENGLAND L. REV. 197 (1973). The court in *Raasch* dismissed a petition for guardianship over a 78 year old woman who had competently refused to undergo a leg amputation and other surgery necessary to prolong her life. As in *Martinez,* the patient advanced no religious objections. She died three months after the dismissal of the petition.

In its discussion of precedent, the *Quinlan* court distinguished a prior New Jersey case in concluding that Karen had a constitutional right to decline medical treatment under certain circumstances. *John F. Kennedy Memorial Hospital v. Heston*[48] concerned a 22 year old Jehovah's Witness who was severely injured in an automobile accident and taken to the plaintiff hospital, where doctors determined that she would die if blood transfusions incident to a necessary operation were not administered. Both the patient and her mother refused to consent to the treatment on religious grounds.[49] The hospital sought, and was granted, a court order for appointment of a guardian to consent to the transfusions.[50] The Supreme Court of New Jersey affirmed the appointment after the transfusions were made. Former Chief Justice Weintraub observed that "[i]t seems correct to say there is no constitutional right to choose to die. . . .Nor is [a] constitutional right established by adding that one's religious faith ordains his death."[51] The *Heston* court, however, was careful to point out that it was not presented with a situation involving certain death, and that the medical treatment contemplated promised a strong chance of recovery. The situation, noted the court, would be different when a terminally ill individual decides to let his illness run a fatal course.[52] The court in *In re Quinlan* concluded that Karen's case fell into this latter category, and distinguished *Heston* on the sole ground that the patient there was "salvable to long life and vibrant health."[53]

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[48] 58 N.J. 576, 279 A.2d 670 (1971).

[49] The court indicated that the competency of the patient to make an informed decision was not clearly established, since despite Miss Heston's statements to the contrary, the evidence showed that she was in shock and incoherent on admittance to the hospital. 279 A.2d at 671.

[50] The lower court limited the forced transfusions to only the amount necessary to preserve Miss Heston's life. *Id.*

[51] *Id.* at 672.

[52] *Id.* at 673. Since the *Quinlan* court was not faced with a situation in which a terminal patient was asserting a very strong religious claim instead of a claim of religious "neutrality," *see* text accompanying note 22 *supra*, its opinion would not appear to foreclose the possibility left open in *Heston* of basing the right to die upon a claim of religious freedom.

[53] 355 A.2d at 663. The *Quinlan* court's manner of distinguishing *Heston*, therefore, seems to be consistent with its notion that in a given case the medical prognosis must be very dim before the state's interest in preserving life will be subordinated to the patient's right to choose to die. There is no mention in *Heston* of a right of privacy or a prohibitive degree of bodily invasion. In any event, the facts of that case would have made it exceedingly difficult to protect Miss Heston's claim of a right to die, since in reality she made no such claim, and very much wanted to live. The patient and her family were opposed only to the blood transfusions, not the required surgery. 279 A.2d at 673. *See* Byrn, *supra* note 3, at 17. Therefore, the court's broad statement

In any event, under the *Quinlan* test of balancing the state's interest in preserving life against the patient's medical prognosis and degree of bodily invasion, the result in *Heston* would be justified, since the patient's chance of recovery was very good and her degree of invasion comparatively minimal.

The balancing process[54] which the New Jersey Supreme Court utilized in *Quinlan* to decide when a person's claim of a right to die supersedes the state's interest in protecting life presents one significant difficulty. The crux of the problem is that the degree of bodily invasion weighed against the state's interest in preserving life must be measured in terms of the extent of treatment at the time of suit. When the supreme court decided *In re Quinlan,*[55] it could state that the degree of bodily invasion was very great, since Karen required 24 hour intensive nursing care, antibiotics, a catheter, an intravenous feeding apparatus, and a respirator. As a result of the decision, however, Karen was removed from her intensive care unit and "weaned" from the respirator.[56] Nevertheless, she continued to live. While her chances for recovery remained as minimal as always, the degree of physical bodily invasion significantly decreased.

By weighing the degree of bodily invasion and the patient's slight chance of recovery against the state's interest in preserving life, the New Jersey court was forced to rely on a medical and factual setting which was variable and unstable. This necessarily raises the question whether with each change in the degree of bodily invasion the balancing test should be repeated. Initially, it would seem that under the court's analysis this question must be answered in the affirmative, and that in a case such as Karen's, where the life-support devices are withdrawn pursuant to the patient's right and yet the patient continues to live, the decrease in bodily invasion makes the state's interest in preserving life overriding even though the medical prognosis remains dim. A distinction must be made, however, between a decrease in bodily invasion because the patient exercised his constitutionally protected right to refuse treatment and the decrease in bodily invasion due to an improvement in the patient's condition. Only in the latter situation should the balancing test be repeated and the decrease in bodily invasion be taken into account in determining whether the state's interest in protecting the patient's life is control-

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negating a constitutional right to choose to die should only be regarded as dictum inapplicable to the very different facts in *Quinlan.*

[54] *See* text accompanying note 35 *supra.*

[55] March 31, 1976.

[56] N.Y. Times, June 10, 1976, at 31, col. 8.

ling. Otherwise, the very exercise of the right to refuse or remove life-prolonging treatment would serve to increase the state's interest and prevent the patient who continues to live after the treatment is removed from dying without interference, though the medical prognosis remains continually hopeless.

For this reason, the predominant factor in gauging the state interest should not be the degree of bodily invasion but the dimness of the medical prognosis for recovery. As the *Quinlan* case illustrates, a patient's ability eventually to perform simple bodily functions without the aid of machines does not mean that her overall prognosis has improved. Since the problem of a high degree of bodily invasion is ancillary to the principal medical judgment that a patient has no meaningful chance of recovery, the presence of a dim medical prognosis should be determinative. If not, the delicate balancing of constitutional right and legitimate state interest would be subject to revision as the degree of bodily invasion changes over time, and the entire process would assume an undesirable degree of impermanence and uncertainty.[57]

The supreme court also considered the problem of who was to exercise Karen's right to reject life-prolonging treatment given her obvious inability to do so. Chief Justice Hughes was clear as to Karen's prerogative to exercise her right were she able, stating that "if Karen were herself miraculously lucid for an interval. . .and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death."[58] Since no such lucidity appeared likely, however, the court granted to her guardian the authority to exercise this right.[59] Although constitutional rights are personal in nature[60] and therefore exercisable on behalf of the individual by a guardian,[61] the vicarious exercise of a right of privacy raises problems because of

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[57] In addition to the uncertainty that this situation entails in the context of the constitutional balancing test, it has practical effects on the defining of the areas of medical and legal responsibility in cases such as Karen's. *See* text accompanying note 92 *infra*.

[58] 355 A.2d at 663.

[59] *Id.* at 664.

[60] Jones v. City of Opelika, 316 U.S. 584, 594 (1942); Schneider v. State, 308 U.S. 147, 161 (1939).

[61] *See* R. MACKAY, GUARDIANSHIP LAW 52 (1948). In 44 C.J.S. *Insane Persons* § 49 (1945) it is stated that "[t]he incompetent being legally incapable of acting for himself, his guardian. . .acts for him, as his personal representative, and the. . .guardian generally becomes substituted for his ward, with reference to all his interests." (footnotes omitted).

the uniquely personal relation of this right to the individual himself.

The United States Supreme Court has considered the possibility of a guardian's abuse of a child's constitutional right of religion, a personal right whose exercise by another poses problems similar to those encountered when the right of privacy is vicariously exercised. In *Prince v. Massachusetts,*[62] the Court upheld State laws regulating the employment of children in the face of a constitutional attack by a Jehovah's Witness who alleged that the laws impinged upon the rightful exercise of her child's religious convictions. Mr. Justice Rutledge noted that while parents are free to exercise their own rights as they see fit, they are not free to exercise their children's rights to their detriment, thereby making "martyrs of their children."[63] While *Prince* dealt with a parent's assertion of her child's right of free exercise of religion, and not a guardian's assertion of his ward's right of privacy, its rationale would seem to be important in the latter case, especially when exercise of the ward's right presumably would lead to his death. The *Quinlan* court, however, reasoned that to refuse Karen's father the authority to exercise Karen's right of privacy would effectively nullify the right altogether. The court stated:

> If a putative decision by Karen to permit this noncognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy. . .then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment. . .as to whether she would exercise it in these circumstances.[64]

The quantum leap which permits Karen's guardian to exercise her right to die is a large but necessary one.[65] Under the circumstances, any judicial pronouncement which recognized Karen's right, but for-

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[62] 321 U.S. 158 (1944).

[63] *Id.* at 170. *See also* Eisenstadt v. Baird, 405 U.S. 438 (1972). The *Eisenstadt* case involved a Massachusetts statute prohibiting the distribution of contraceptives to unmarried persons which was struck down on the grounds, *inter alia,* of a violation of the right of privacy. The Court stated that "[i]f the right of privacy means anything, it is the right of the *individual,* married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Id.* at 453.

[64] 355 A.2d at 664.

[65] Both the lower and appellate courts in *Quinlan* refused to recognize any of the rights that Karen's parents asserted in their own right. *See* text accompanying notes 24 and 26 *supra.*

bade its effectuation by anyone other than Karen would have given hollow relief. Moreover, the court's ruling that a guardian can exercise his ward's right of privacy is not entirely without support. In *Commonwealth v. Wiseman,*[66] the Commonwealth, suing as parens patriae, sought an injunction prohibiting the showing of a documentary film depicting the inmates of a state mental institution in highly personal and humiliating situations. The Commonwealth argued that it had standing as the guardian of the inmates to enjoin the invasion of their privacy. The court, in substantially granting the relief requested, stated that the Commonwealth had a duty reasonably to protect the inmates from violation of their privacy rights, and that its standing in court was predicated solely upon this duty to assert the wards' interests.[67] Thus, while the rights of privacy being exercised in *Quinlan* and *Wiseman* differ in origin and ultimate purpose, *Wiseman* indicates that *Quinlan* is not the first case to authorize third-party exercise of such personal rights.[68]

Finally, the *Quinlan* court did not vest the guardian with unlim-

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[66] 356 Mass. 251, 249 N.E.2d 610 (1969), *noted in* 83 HARV. L. REV. 1722 (1970).

[67] 249 N.E.2d at 615-16.

[68] The standing of a third party to exercise an incompetent's right of privacy has been sustained in situations where the violation of such right gives rise to liability in tort to the incompetent person. This right of privacy springs not from a constitutional basis, but rather from a common law right to be compensated for or equitably relieved from a substantial or indecent intrusion upon the private life of a person. *See* Kalven, *Privacy in Tort Law—Were Warren and Brandeis Wrong?*, 31 L. & CONTEMP. PROB. 326 (1966); Prosser, *Privacy*, 48 CALIF. L. REV. 383 (1960); Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890). Some states have given this right by statute, *e.g.*, N.Y. CIV. RIGHTS § 51 (McKinney 1976), which provides for relief to "[a] person whose name, portrait or picture is used within this state for advertising purposes or for the purposes of trade without. . .written consent. . . ." The right is based in tort law and relates primarily to the unauthorized publicizing or exploitation of an individual's affairs. It is thus distinct from the constitutional right of privacy, although as *Quinlan* and *Wiseman* illustrate, both rights have been held to be exercisable by a guardian of the individual.

However, such an exercise should not be confused with cases where courts have allowed recovery on the basis of a relational right of privacy theory to a parent, spouse, or relative of a decedent whose privacy has been invaded. In such a case the plaintiff is usually not attempting to recover for injury to the decedent's feelings or sensibilities, but for his own injury. *See* Comment, *Why Not a Relational Right of Privacy?—or Right of Property?*, 42 U. MO.—KANS. CITY L. REV. 175, 181 (1973). An example is Bazemore v. Savannah Hosp., 171 Ga. 257, 155 S.E. 194 (1930), where the court allowed recovery to the parents of a deceased, deformed child whose photographs had been published with defendant's permission. The court noted that any injury to the child was not the basis for recovery; rather the right of action was owned by the parents and did not depend on a survival of the child's right after his death. *Id.* at 260, 155 S.E. at 196.

ited discretion to make the decision according to the dictates of his own values and preferences; instead he is to render his best judgment as to how Karen would decide in these circumstances.[69] This formulation would seem to allow for the consideration in future cases of documents such as living wills[70] or antidysthanasia contracts[71] as

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[69] 355 A.2d at 664.

[70] *See* Kutner, *The Living Will—Coping With the Historical Event of Death*, 27 BAYLOR L. REV. 39 (1975); Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969); Note, *Living Wills—Need for Legal Recognition*, 78 W. VA. L. REV. 370 (1976). The living will is a non-legal instrument indicating an individual's desire not to be subjected to life-prolonging medical techniques in the event of a terminal illness. It is signed by the patient and two witnesses, is usually carried on his person, and is revocable by the signatory.

Recently, California enacted a Natural Death Act which gives legal effect to such an instrument. California Natural Death Act, ASSEMBLY BILL No. 3060 (1976), to be codified at CAL. HEALTH & SAFETY CODE §§ 7185 *et. seq.* (West Supp. 1977). When executed by an adult patient "voluntarily and in sound mind" not less than 14 days prior to being notified that his condition is "terminal," the directive expressly authorizes the withholding or withdrawal of life-sustaining procedures. The directive, signed by the patient and two witnesses, is generally effective for five years unless revoked by the signatory. "Terminal condition" is defined as:

> an incurable condition caused by injury disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve [sic] only to postpone the moment of death of the patient.

§ 7187(f).

The bill further relieves physicians and hospitals from any civil or criminal liability for withholding or withdrawing the life-sustaining procedures, but provides that a failure by a physician to effectuate his patient's directive shall constitute unprofessional conduct if he fails to transfer the patient to another physician who will comply with the directive. If the patient becomes comatose, the directive shall remain in effect for the duration of the comatose condition.

The authors of the bill based the right of an adult patient to make such a living will upon "the dignity and privacy which patients have a right to expect," and expressly disavowed any intention of condoning, authorizing, or approving mercy killing or any other affirmative act to end life in the absence of a directive. As *Quinlan* illustrates, however, the absence of a living will does not mean that an individual's constitutional right to die may not be effectuated, at least in New Jersey. If the patient has not made a living will and is not competent to make the decision, under *Quinlan* the guardian still may make the decision according to his best judgment as to how the patient himself would decide.

[71] The anti-dysthanasia proposal is for a binding legal contract between the patient and his physician (or hospital) which would obligate the latter to give effect to an individual's expressed desire to die upon becoming terminally ill. The contract could be executed before or after the patient becomes terminal, providing he is competent to enter into the agreement. Consideration is furnished by the doctor's promise to perform and the patient's promise to pay for future services. Remedies for breach would include damages for all medical fees and expenses incurred after the time at

valid indicia of the patient's intentions, thereby minimizing the concern expressed by some courts that decisions relating to the bodily integrity of children or incompetents could be made by parents or guardians without respect for the patient's wishes.[72] Given the court's ruling that since statements made by Karen prior to her incompetency concerning her distaste for continuance of life by artificial means were remote, impersonal, theoretical, and not made in a situation where Karen's own life was at stake, they were without probative weight,[73] these documents would seem to be the only type of probative evidence admissible to show a patient's intent. Still, the decision casts doubt on the reliability of even this type of evidence, since it would seem subject to the same defects which the court found in Karen's prior statements.

Thus, if there can be no cogent evidence of a patient's intentions, or if none is available,[74] the conclusion is inescapable that in entrusting the death-or-life decision to a guardian, the courts are allowing him to make a value judgment concerning the quality of the life of another person, and then giving legal protection to that judgment. The consequences of such a decision will often be absolute and irreversible, but the *Quinlan* court decided that Karen's guardian must be allowed to make the decision if the right of privacy was to have any meaning at all. Based on extensive examination of the plaintiff's motivations and beliefs, the court was confident that he was in the best position to make the decision.[75] This essentially moral judgment that the family unit[76] constitutes the most appropriate forum for

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which the signatory would have died absent life-prolonging treatment, as well as an action for specific performance. *See* Comment, *Antidysthanasia Contracts: A Proposal for Legalizing Death With Dignity*, 5 PAC. L.J. 738 (1974).

[72] *See* Strunk v. Strunk, 445 S.W.2d 145, 149 (Ky. 1969) (Steinfeld, J., dissenting).

[73] 355 A.2d at 653. *Cf. In re* Estate of Brooks, 32 Ill.2d 361, 205 N.E.2d 435, 442 (1965) (where statements considered because court concluded they were made with an awareness of consequences). *See also* Morgan, *Hearsay Dangers and the Application of the Hearsay Concept*, 62 HARV. L. REV. 177 (1948).

[74] One would assume that young and healthy people who become terminally ill as the result of accident or unforeseeable circumstances generally would not have executed living wills. Thus, that type of evidence probably will not play a controlling role in cases such as Karen's, absent much wider use of such documents and more state legislation to guarantee their effectiveness. *See* note 70 *supra*. Moreover, given the court's characterization of such evidence as remote, theoretical, and without probative weight, it would not be controlling. *See* text accompanying note 73 *supra*.

[75] After a comprehensive examination, the court concluded that Mr. Quinlan's "strength of purpose and character" qualified him eminently for the guardianship of his daughter. 355 A.2d at 671.

[76] In deciding to grant to Karen's father guardianship over the person of his daugh-

decision should ensure that, in most cases, the guardian will have the patient's best interests at heart. Further protection of the patient's intentions is provided by the court's requirement that an Ethics Committee, which would examine the motivations and good faith of the parent or guardian requesting termination of care, approve any decision to withdraw life-support treatment.[77]

In ruling that the decision to refuse or to remove life-sustaining treatment belonged to the patient in exercise of his right of privacy, the supreme court rejected the trial court's holding that the decision was solely a medical one.[78] The *Quinlan* court, however, did not rule that medical judgment was an unimportant consideration. Indeed, it expressly held that whether there exists a situation in which a patient may exercise his right to die depends on a medical prognosis "as to the [patient's] reasonable possibility of return to cognitive and sapient life. . . ."[79] This interplay of the patient's constitutional right with the duty and privilege of the treating physicians to act in accordance with standard medical procedure[80] raises issues concerning the interrelation of judicial and medical responsibility in cases of this kind.

While according great deference to the importance of standard medical procedure, the supreme court nonetheless promulgated a new test for the applicability of such standards to specific situations where the patient or his family are opposed to imposition or continuation of treatment. It ruled that if an internal inconsistency exists between the procedure required by the professional standard applicable to a particular situation and what, in fact, doctors actually do in these situations, then the standard would not bar exercise of the

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ter, the supreme court noted that the state statute authorizing judicial appointment of guardians, N.J. STAT. ANN. § 3A:6-36 (West Supp. 1976), creates an initial presumption of entitlement to guardianship of the next of kin. 355 A.2d at 670. This section was designed to eliminate the former practice of New Jersey courts of commonly appointing a friend of the court as guardian instead of the incompetent's next of kin. *See In re* Roll, 117 N.J. Super. 122, 283 A.2d 764 (1971).

[77] 355 A.2d at 668-69. *See* text accompanying note 88 *infra.*

[78] 137 N.J. Super. at 260, 348 A.2d at 818-19. The trial court stated that since the duty of caring for terminally ill patients is imposed by society on physicians, there is no justification for removing the decision-making power attendant to such duty from the control of the medical profession. Therefore, the decision may be concurred in by the parents or guardian of the incompetent but the final responsibility lies with the physician, since the parents' motivations are always open to question.

[79] 355 A.2d at 669.

[80] The right of physicians to practice the profession of their choice, free from undue interference by the state, has been accorded constitutional status. Young Women's Christian Ass'n v. Kugler, 342 F. Supp. 1048, 1055 (D.N.J. 1972).

patient's right.[81] Thus, if there is evidence that physicians authorize termination of life-support treatment without reference to this standard, then there is a lack of consistency within the medical profession concerning when and how the standard should be applied, and under the court's test the plaintiff should not be prevented from obtaining relief.

In *Quinlan,* the court found this evidence in the admitted existence within the ambit of standard medical procedures of "judicious neglect." Simply stated, the concept embodies an unwritten and unspoken practice among physicians to discontinue treatment of a patient when "it does not serve either the patient, the family, or society in any meaningful way to continue treatment. . . ."[82] The court reasoned that to discontinue treatment in some cases by resort to such a practice, while refusing to disconnect the respirator in Karen's case because technically she was not brain dead,[83] did not follow an internally consistent medical methodology, especially since judicious neglect is practiced in many cases where patients are clearly not brain dead.[84]

In spite of its conclusion that the asserted medical standards did not bar the relief which the plaintiff sought, the court's decision should not overly intrude into the physician's traditional realm of medical ethics and expertise. First, the formulation of the prognosis as to a possible return by the patient to cognitive and sapient life remains a uniquely medical function, and that prognosis constitutes the crucial factor in determining whether the patient's claim of a right to die will override the state's interest in protecting his life.[85]

Second, the court was cognizant of the doctor's dilemma as evidenced by the two undesirable consequences that might flow from a physician's participation in removal of life-support treatment: possible civil or criminal liability and a perceived violation of the doctor's ethical duty to heal and sustain life. Taking into account the high standard of respect that this duty commands,[86] the court specifically

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[81] 355 A.2d at 666.

[82] *Id.* at 657 (testimony of Dr. Julius Korein). The same concept is given effect when, in a notation, the physician writes the three initials "D.N.R."—do not resuscitate. *Id.*

[83] For a discussion of the concept of brain death, see note 9 *supra.*

[84] 355 A.2d at 667.

[85] *See* text beginning at note 55 *supra.*

[86] 355 A.2d at 668. The court noted that physicians alone are charged with the duty of making ethical judgments in the course of practice that others are ill-equipped to make. This ethical duty not only requires doctors to exercise good faith judgment in very difficult and uncertain situations, but also imposes upon physicians a civil or

relieved Karen's physicians and hospitals from all such liability.[87] In recognition of this solicitude towards the physicians' problems and the heavy reliance placed upon medical prognosis and participation in the decision-making process, *In re Quinlan* should not be regarded as a vindication of the personal freedom to do with oneself as one wishes in derogation of medical conscience and practice. Instead, the decision illustrates the exacting delineation necessary to outline the appropriate zones of judicial and medical responsibility.

To insure that any decision by the guardian and the treating physicians to remove life-sustaining treatment is grounded in a sound medical prognosis and a moral judgment consistent with the patient's own desires, the court required the involvement of an Ethics Committee as a consultative body for the purpose of reviewing the decision.[88] The court suggested that the Committee consist of physicians, social workers, theologians, and attorneys[89] who would examine the medical correctness of the prognosis, the motives of the interested parties, and the advisability of implementing the decision to withdraw the life-prolonging treatment.[90]

This approach has several advantages.[91] The moral responsibility for making such an awesome judgment is shared by persons other than the guardian and the treating physicians.[92] Thorough examina-

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criminal liability that they frequently do not even realize as a factor in the decision-making process. *See also* AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS, *reprinted in* W. CURRAN & E. SHAPIRO, LAW, MEDICINE AND FORENSIC SCIENCE (2d ed. 1970).

[87] *See* text accompanying note 95 *infra*.

[88] 355 A.2d at 668-69. The impetus for the court's adoption of the Ethics Committee concept came from a proposal in Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6 (1975).[Hereinafter cited as Teel.]

[89] The court noted that this conception of the precise organization of the Committee, which was Dr. Teel's, *see* Teel, *supra* note 88, at 8-9, would not have to be specifically implemented; a "reasonable counterpart" would be equally effective. 355 A.2d at 669.

[90] In a case where the patient himself competently made the decision, the Committee's task presumably would be largely limited to confirming the soundness of the medical prognosis, since the need for investigation of the parent or guardian's ethical motivations would not be present.

[91] *See generally* Teel, *supra* note 88, at 9.

[92] Since the Committee would serve only in an advisory capacity, it presumably would lack the legal status that would permit it to be held liable in a civil or criminal action based on wrongful death or otherwise. The eventual assumption by the Committee of such a legal posture is not foreclosed, however, if its members accept such a responsibility in recognition of the usefulness of such a body's function and the respect it hopefully will command from physicians, patients, and parents. *See* Teel, *supra* note 88, at 9. Even if the Committee retains its present advisory capacity, its final decision

tion and exploration of all issues and facets of particular cases is facilitated. Furthermore, any evidence of "doctor-shopping" on the part of the guardian would be closely scrutinized and considered.[93] Finally, this method permits removing the decision-making procedure from the judicial forum.[94] The supreme court incorporated the Ethics Committee requirement in its final holding in *Quinlan,* where Chief Justice Hughes stated that upon the concurrence of Karen's guardian, should Karen's physicians conclude that there is no reasonable chance of Karen's recovering to a cognitive and sapient state, the hospital Ethics Committee must agree with the conclusions of the physicians and family before the present life-support system may be withdrawn. Once the Ethics Committee gives its approval, "[the] said action shall be without any civil or criminal liability therefor on

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approving or rejecting the guardian's application for termination of care is necessary and binding. *See* text accompanying note 95 *infra.*

[93] Since Karen's guardian was given the express power to appoint her attending physicians, 355 A.2d at 671, it would seem that the court could not help but realize that the decision would permit a guardian to procure selectively the services of doctors whose prognoses would permit the carrying out of the guardian's wishes despite strong opposition from family members or the state. However, the Ethics Committee would investigate the factual bases of the prognosis and would not approve the decision if the prognosis were not in accord with sound medical judgment. Since Committee approval must be obtained if the patient's right to have the treatment withdrawn is to be exercised, this would provide a strong deterrent. Nevertheless, if doubt remained as to the propriety of a decision, the court emphasized that the judicial forum would remain open as the appropriate vehicle for resolution of the conflict. 355 A.2d at 669.

[94] The *Quinlan* court noted its perception of the judicial forum as inappropriate in cases of this kind, stating that "a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome." 355 A.2d at 669. *See* Powell v. Columbian Presbyterian Medical Center, 39 Misc.2d 215, 267 N.Y.S.2d 450, 452 (1965).

One commentator on *Quinlan* has taken the position that due to the limitations of the judicial approach, the question of determining whether to permit termination of care is better left to the legislature, which is more able to determine the social policy involved in deciding if human life should in all cases be preserved. Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State,* 51 N.Y. U.L. REV. 285 (1976). It does not follow, however, that courts, notwithstanding their capacity to adjudicate individual conflicts, should not declare the nature and extent of the patient's right to refuse care. Even if the court's result is later modified or repudiated by the legislature, this possibility should not deter the court from accepting and deciding cases in new areas of social welfare. The type of "judicial activism" evidenced by the New Jersey Supreme Court should not be seen as a usurpation of the legislature's job; rather, the court's decision represents an attempt to reach a final disposition of the issues as befits its role as an institution that truly resolves grievances. *See* White, *The Evolution of Reasoned Elaboration: Jurisprudential Criticism and Social Change,* 59 VA. L. REV. 279, 300 (1973).

the part of any participant, whether guardian, physician, hospital or others."[95]

By providing a non-judicial mechanism for reviewing the propriety of an individual's decision to die, the court eliminated the substantial formalities attendant to a legal proceeding. Such an approach is more flexible and responsive to the extra-legal factors involved in any decision to reject or withdraw life-support treatment. Moreover, the basis of the decision in *Quinlan* evolves not only from an affirmance of the patient's constitutional rights, but also from the practice of the medical profession concerning judicious neglect[96] and an express belief by the court that society in general would support Mr. Quinlan's prayer for relief.[97] The judicial system has no particular expertise in the determination of these latter two factors. Furthermore, a medical situation which is subject to change at any time requires day-to-day observation and decision-making. A condition regarded as irreversible today might become more hopeful tomorrow. In such circumstances, the court's need to decide issues based on facts existing at the time of suit precludes the type of continuous, realistic reappraisal that is essential.

In re Quinlan represents the New Jersey Supreme Court's sincere effort to resolve one of the most complex dilemmas of modern society—the moral and legal rectitude of a decision to withdraw life-prolonging medical treatment from an irreversibly dying patient. Sustaining a claim by the patient's parents that they be allowed to exercise Karen's constitutional right of privacy, the court recognized that this right contemplates the ability of the patient to refuse life-support mechanisms when faced with no possibility of recovery or return to meaningful existence. The court further acknowledged the importance of the standards and conscience of the medical profession when confronted with this problem, but emphasized that the inviolability of medical judgments and procedures must give way in certain circumstances to the exercise of the patient's constitutional rights.

The opinion should not be read as destroying or minimizing the traditional legal presumption in favor of life.[98] Such is not its import,

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[95] 355 A.2d at 671.

[96] *See* text accompanying note 82 *supra.*

[97] 355 A.2d at 664. The court stated that it thought Mr. Quinlan's decision to seek termination of the processes keeping his daughter alive should be accepted by society in general, whose members would, when faced with similar circumstances, react in the same way.

[98] *Cf.* Application of the President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1009-10 (D.C. Cir. 1964), where an order for a blood transfusion was required

especially in view of its recognition of the inherent limitations of the court as a forum for resolving questions concerning the quality and meaning of life. While the relative paucity of in-depth constitutional analysis might suggest that the court first made a moral judgment as to the propriety of sanctioning a person's death and then searched for the constitutional authority to support its conclusion, such a method of decision-making is not necessarily suspect. There was no substantial precedent from which to derive guidance and support, and the court recognized that the problem in its final analysis is not a legal one. Nonetheless, the court considered all issues and appreciated the import of what it was called upon to decide. In the context of the tragic case that confronted it, the court's effort is a humble attempt to provide a legal solution, however flawed, to a problem that defies easy or correct resolution.[99]

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if the patient was not to die. Judge Wright stated that "[t]he final, and compelling, reason for granting the emergency writ was that a life hung in the balance. There was no time for research and reflection . . . I determined to act on the side of life."

[99] Since *Quinlan* was handed down three cases have granted similar relief in situations involving the withholding of life-support treatment: Dockery v. Dockery, No. 51439 (Hamilton County Ch. Ct. Tenn., Feb. 11, 1977); *In re* Cain, File No. 76-130-95 (Duval County Ct. Fla., Dec. 6, 1976); Jones v. Saikewicz, No. S.J.C.-711 (Sup. Jud. Ct. Mass., July 9, 1976). *Dockery* and *Cain* are unreported trial court decisions which are expected to be appealed. *Saikewicz* was disposed of by an order of the court; an opinion is expected but was unavailable at the time of this writing.