

NOTES

THE REFUSAL OF LIFE-SAVING MEDICAL TREATMENT VS. THE STATE'S INTEREST IN THE PRESERVATION OF LIFE: A CLARIFICATION OF THE INTERESTS AT STAKE

The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

John Stuart Mill,
On Liberty

No man is an *Iland*, intire of its selfe; every man is a piece of the *Continent*, a part of the *maine* . . . any man's death diminishes *me*, because I am involved in *Mankinde*; And therefore never send to know for whom the *bell* tolls; It tolls for *thee*.

John Donne
Devotions upon Emergent Occasions

I. INTRODUCTION

The question of the right to refuse life-saving medical treatment would provoke only limited interest in a society in which all sick people either died or fully recovered, for few would refuse treatment given only those alternatives.¹ Modern medical science, however, sometimes offers a third alternative: the preservation or prolongation of life without restoration of health. As a result, incurably ill patients may live longer, often in pain or discomfort, before succumbing to their illnesses; unconscious patients may survive for longer periods of time but in comatose states; patients may survive radical surgery only to find themselves unable to adjust to their physically altered conditions; severely defective infants may be kept alive without a cure of their underlying defects.² Many question the value of medical treatment that

1. An exception would be those few whose religious convictions oppose a particular type of treatment, for example, those who believe a blood transfusion would preserve physical life but at the cost of everlasting spiritual life. See notes 9-16 *infra* and accompanying text.

2. For the significance and description of some of the new medical capabilities, see, e.g.,

enhances the length of life while diminishing its quality, and increasing numbers of patients or their families are refusing such life-saving treatment.³ "Death with dignity" is their request.

The state has challenged a patient's right to choose death by "passive euthanasia,"⁴ arguing that the patient's willingness to die does not waive the state's overriding interest in preserving life. To support its argument, the state may point to other policies stemming from government's concern for the lives of individuals who apparently have no concern for their own, for example, prohibition of suicide,⁵ snake-handling,⁶ helmetless motorcycling,⁷ and other forms of voluntary risk-tak-

Bellegie, *Medical Technology as it Exists Today*, 27 BAYLOR L. REV. 31 (1975); Biörck, *When is Death?*, 1968 WIS. L. REV. 484, 493.

3. D. CRANE, *THE SANCTITY OF SOCIAL LIFE: PHYSICIANS' TREATMENT OF CRITICALLY ILL PATIENTS* 1-2, 211-12 (1975).

4. Euthanasia, loosely defined, is causing or deliberately allowing one to die when death seems preferable to life. Active euthanasia is causing death by some act; passive euthanasia is deliberately allowing death to result from natural causes by omitting to do something that would save life.

Withholding or terminating treatment, including the act of turning off a respirator, is passive euthanasia. *E.g.*, Cantor, Quinlan, *Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 263 n.107 (1977); Foote, *Euthanasia*, 6 PHILOSOPHY & PUB. AFF. 86, 101 (1977).

5. Anglo-American law has a long history of anti-suicide policy. *See generally* N. ST. JOHN-STEVAS, *LIFE, DEATH & THE LAW* 232-61 (1964); G. WILLIAMS, *THE SANCTITY OF LIFE & THE CRIMINAL LAW* 248-310 (1957).

No state makes suicide a crime, although some states criminalize attempting or aiding and abetting suicide. W. LAFAVE & A. SCOTT, JR., *CRIMINAL LAW* 569 (1972); 7 N.C. CENT. L.J. 156 (1975). All states seem to permit and even encourage interference with attempted suicides, and some statutes allow the use of reasonable force to do this. Byrn, *Compulsory Life-saving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 16 (1975).

Only one case challenged the validity of a suicide-related statute, but the court did not reach the constitutional issues. *Penney v. Municipal Ct.*, 312 F. Supp. 938 (D.N.J. 1970) (defendant, on trial in state court for attempted suicide, sought declaratory and injunctive relief from federal court; court held no substantial federal question existed at that point, but left open the possibility of considering the statute's constitutionality in appeal from criminal conviction).

6. Enforcement of anti-snake-handling statutes against persons who use snakes in religious ceremonies has been declared constitutional by several state courts. At least three of these courts have said that the state may prevent handlers and participants from voluntarily incurring the risk of deadly snake bites. *See Lawson v. Commonwealth*, 291 Ky. 437, 164 S.W.2d 972 (1942); *Swann v. Pack*, 527 S.W.2d 99 (Tenn.), *cert. denied*, 424 U.S. 954 (1976); *Harden v. State*, 188 Tenn. 17, 216 S.W.2d 708 (1948); *cf. Hill v. State*, 38 Ala. App. 404, 88 So. 2d 880 (state may protect the public from the danger of escaping snakes), *cert. denied*, 264 Ala. 697, 88 So. 2d 887 (1956); *State v. Massey*, 229 N.C. 734, 51 S.E.2d 179, *appeal dismissed sub nom. Bunn v. North Carolina*, 336 U.S. 942 (1949) (same); *Kirk v. Commonwealth*, 186 Va. 839, 44 S.E.2d 409 (1947) (preacher whose wife was killed by snake during religious service may be prosecuted for murder).

7. Statutes requiring that motorcyclists wear helmets have met a mixed fate in the courts. *See generally* Annot., 32 A.L.R.3d 1270 (1970). Some courts have explicitly upheld the require-

ing.⁸ Thus, the state may argue that the compulsion of life-saving medical treatment is merely another instance of its traditional concern for life.

In deciding refusal-of-treatment cases, the courts must reconcile this conflict between the patient's assertion of a right to choose a course that will result in death and the state's claim of an interest in the preservation of life. This Note analyzes the individual's interest in refusing treatment, the state's interest in compelling it, and recent trends in the courts' weighing of the opposing interests.

ments as permissibly protecting the cyclist's life despite the cyclist's own willingness to risk it. *See State v. Eitel*, 227 So. 2d 489, 490-91 (Fla. 1969) (state may preserve life of individual "for his own sake," for some "divinely ordained and humanely explicable purpose"); *State v. Lee*, 51 Hawaii 516, 518, 465 P.2d 573, 576 (1970) (state has valid interest in preventing threat to "the very fabric of society" posed by increasing number of deaths and injuries to motorcyclists); *People v. Carmichael*, 56 Misc. 2d 388, 390, 288 N.Y.S.2d 931, 935 (Genesee County Ct. 1968) (quoting Sunday labor law case stating "It is in the interest of the state to have strong, robust, healthy citizens, capable of self-support, of bearing arms and of adding to the resources of the country."); *accord*, *Bisenius v. Karns*, 42 Wis. 2d 42, 51, 165 N.W.2d 377, 382 (dictum) (judge upheld statute on other grounds, but might have upheld it even if its only aim were to "protect persons against the consequences of their own actions"), *appeal dismissed*, 395 U.S. 709 (1969). Other courts have found the statutes unconstitutional, saying that laws intended to protect one who does not want protection, and who is not endangering others, are beyond the scope of the police power. *See, e.g.*, *People v. Fries*, 42 Ill. 2d 446, 250 N.E.2d 149 (1969); *American Motorcycle Assoc. v. Davids*, 11 Mich. App. 351, 158 N.W.2d 72 (1968), *overruled*, *City of Adrian v. Poucher*, 67 Mich. App. 133, 240 N.W.2d 298 (1976); *State v. Betts*, 21 Ohio Misc. 175, 252 N.E.2d 866 (Franklin Mun. Ct. 1969). A third approach has been to uphold the statutes as protecting the public rather than the cyclist. One popular theory is that a helmetless cyclist may be hit on the head by a flying stone or in the eye by a speck of dirt, and an accident endangering innocent persons may result. *See Everhardt v. City of New Orleans*, 253 La. 285, 217 So. 2d 400, *appeal dismissed*, 395 U.S. 212 (1968); *Commonwealth v. Howie*, 354 Mass. 769, 238 N.E.2d 373, *cert. denied*, 393 U.S. 999 (1968); *State v. Krammes*, 105 N.J. Super. 345, 252 A.2d 223 (App. Div.) (per curiam), *cert. denied*, 54 N.J. 257, 254 A.2d 800 (1969); *State v. Mele*, 103 N.J. Super. 353, 247 A.2d 176 (Hudson County Ct. 1968); *State v. Anderson*, 3 N.C. App. 124, 164 S.E.2d 48 (1968), *aff'd*, 275 N.C. 168, 166 S.E.2d 49 (1969); *State v. Lombardi*, 104 R.I. 28, 241 A.2d 625 (1968); *Bisenius v. Karns*, 42 Wis. 2d 42, 165 N.W.2d 377, *appeal dismissed*, 395 U.S. 709 (1969). *But see* 67 MICH. L. REV. 360, 368-69 (1968) (no evidence that helmets protect anyone but the motorcyclist). Other public interests courts have cited include the cost of publicly supplied hospital and ambulance services for indigent injured cyclists, *State v. Laitinen*, 77 Wash. 2d 130, 134, 459 P.2d 789, 791-92 (1969), *cert. denied*, 397 U.S. 1055 (1970), and the inconvenience of caring for the injured motorcyclist, *State v. Eitel*, 227 So. 2d 489, 491 (Fla. 1969).

8. One motorcycle-helmet case cited examples such as prohibiting aerial performances without a net and requiring hunters to wear brightly colored jackets. *Bisenius v. Karns*, 42 Wis. 2d 42, 51, 165 N.W.2d 377, 382 ("the concept that it is my neck and I have a right to risk it . . . has had some limitations placed upon its application."), *appeal dismissed*, 395 U.S. 709 (1969).

The current controversy over the use of laetrile provides another example of many states' refusals to allow persons to willingly undertake something the state views as a risk. *See People v. Privitera*, 23 Cal. 3d 697, 591 P.2d 919, 153 Cal. Rptr. 431 (1979).

II. THE CASES ON COMPULSORY LIFE-SAVING MEDICAL TREATMENT

The classic compulsory-treatment cases generally involved patients who refused life-saving blood transfusions on religious grounds despite the promise of fully restored, good health.⁹ Patients in the more recent cases question the value of treatment that cannot restore good health. In both the older and newer cases, courts have faced two questions: first, under what circumstances, if any, may a competent patient refuse life-saving medical treatment; second, how is a treatment decision to be made for an incompetent patient?¹⁰

A. *Refusal of Treatment*

Courts have established two broad bases for compelling life-saving treatment over a patient's refusal. First, the courts consider whether the patient's death may harm other persons, particularly the patient's children or the attending medical personnel.¹¹ Second, courts determine whether the state may have an interest in preserving the patient's life despite the absence of ascertainable harm to others.

The blood-transfusion cases are the basic precedents for the state's right to compel treatment in order to protect third parties' interests in the patient's life. The leading case is *In re Georgetown College*,¹² in which the Georgetown hospital sought court permission to administer an emergency transfusion to the mother of a seven-month-old child. In support of its order for transfusions,¹³ the court reasoned that the patient could not, by allowing herself to die, abandon her child and thereby evade her responsibility to care for it.¹⁴ The court further rea-

9. Some Christian denominations believe the Biblical prohibition against eating blood also applies to blood transfusions. The transfusion cases largely pre-date the modern controversy over passive euthanasia and provide the largest single body of precedent for the newer cases.

10. Although most of the cases do not articulate these questions, the two questions are implicit in the cases and this approach, therefore, facilitates analysis.

11. See notes 14-16 *infra* and accompanying text.

12. 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

13. Courts usually do not actually order treatment, but appoint a guardian to consent to it; in this case, however, the judge himself ordered the transfusions. *Id.*

14. *Id.* at 1008.

Other courts, in deciding blood-transfusion cases, have indicated that this reasoning is controlling in appropriate circumstances. *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972); *In re Osborne*, 294 A.2d 372 (D.C. 1972); *In re Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976). Still other medical treatment cases have accepted this principle in dicta. *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist.

soned that the patient could not subject medical personnel to the risk of civil or criminal liability for failure to save her life.¹⁵ Other courts have found the state's interest in the preservation of the ethical integrity of the medical profession compelling; those courts have held that patients may not force medical personnel to violate their own scruples and professional ethics by acquiescing in a patient's death.¹⁶ In blood transfusion cases in which no discernible individual would be harmed, most courts have upheld the patient's refusal of treatment.¹⁷

While continuing to recognize this concern for third parties' interests, the newer medical treatment cases have also placed substantial weight

Ct. App. 1978), *aff'd*, 48 U.S.L.W. 2503 (Fla., Jan. 17, 1980); Superintendent of Belchertown v. Saikewicz, — Mass. —, 370 N.E.2d 417 (1977). See notes 83-88 *infra* and accompanying text.

15. 331 F.2d at 1009; *accord*, John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 582, 279 A.2d 670, 673 (1971); Collins v. Davis, 44 Misc. 2d 622, 623, 254 N.Y.S.2d 666, 667 (Sup. Ct. 1964). See also *In re Quinlan*, 70 N.J. 10, 44-52, 355 A.2d 647, 666-70, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976). See notes 89-91 *infra* and accompanying text.

The *Georgetown* court also based the decision on the grounds that court-ordered treatment did not offend the patient's religious beliefs and that the patient objected only to consenting to the transfusion, not to receiving it. 331 F.2d at 1009. *Accord*, United States v. George, 239 F. Supp. 752, 753 (D. Conn. 1965); Powell v. Columbian Presbyterian Medical Center, 49 Misc. 2d 215, 216, 267 N.Y.S.2d 450, 451 (Sup. Ct. 1965). *Contra*, *In re Osborne*, 294 A.2d 372, 375 (D.C. 1972). Several commentators have argued that a court-ordered transfusion is indeed a serious violation of patients' religious beliefs. *E.g.*, Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 232 n.19 (1973); Paris, *Compulsory Medical Treatment & Religious Freedom: Whose Law Shall Prevail?*, 10 U.S.F.L. REV. 1, 31-34 (1975).

16. See, *e.g.*, United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965); John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 582-83, 279 A.2d 670, 673 (1971). *But cf.* Satz v. Perlmutter, 362 So. 2d 160, 163-64 (Fla. Dist. Ct. App. 1978) (medical ethics may not require saving life in all cases; patients' rights outweigh doctors' interests), *aff'd*, 48 U.S.L.W. 2503 (Fla., Jan. 17, 1980); Superintendent of Belchertown v. Saikewicz, — Mass. —, —, 370 N.E.2d 417, 426-27 (1977) (same); *In re Quinlan*, 70 N.J. 10, 44-48, 355 A.2d 647, 666-67 (medical ethics do not so consistently mandate preservation of life as to constitute complete bar to permitting patient's refusal of treatment), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

See notes 92-95 *infra* and accompanying text.

17. See, *e.g.*, *In re Osborne*, 294 A.2d 372 (D.C. 1972); *In re Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976); *In re Phelps*, No. 459-207 (Milwaukee County Ct. July 11, 1972), *cited in* Sullivan, *The Dying Person—His Plight and His Right*, 8 NEW ENG. L. REV. 197, 198-200 (1973); *cf.* Holmes v. Silver Cross Hosp., 340 F. Supp. 125 (N.D. Ill. 1972) (denying defendant hospital's motion to dismiss, court held that compulsion of medical treatment in violation of patient's religious beliefs states cause of action under § 1983, and violates first amendment unless defendant shows substantial state interest on the facts of the case); Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962) (patient allowed to refuse treatment, on ground that patient had right to determine medical necessity).

on the state's interest in the preservation of life.¹⁸ Without explaining exactly what this state interest might be, two leading cases attempted to balance the state's interest in life against the patient's interest in refusing treatment.

In *In re Quinlan*¹⁹ the New Jersey Supreme Court allowed the father of an unconscious, adult patient to order removal of a life-sustaining respirator. Finding that the constitutional right to privacy protects a competent patient's right to refuse medical treatment, the court held that "as the degree of bodily invasion increases and the prognosis [for resumption of cognitive life] dims," the patient's right to refuse treatment increases.²⁰ The court considered Quinlan's medical treatment sufficiently invasive and the prognosis for her return to consciousness sufficiently poor to outweigh the state's interest in preserving her life.²¹ To protect the unconscious patient's right to terminate treatment, the court authorized her father to make the decision on her behalf.²²

Subsequently, the New Jersey Appellate Court in *In re Quackenbush*²³ modified *Quinlan's* two-pronged balancing test by dropping the requirement of a "dim prognosis" for cognitive life. The *Quackenbush* court allowed an elderly patient with a good prognosis²⁴ to refuse a life-saving amputation, holding that "under the circumstances of this case"

18. Only two blood-transfusion cases considered this state interest. In *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 584, 279 A.2d 670, 674 (1971), it was one of the grounds for compelling treatment. *Contra, In re Osborne*, 294 A.2d 372, 375 n.5 (D.C. 1972). For an argument that the state's interest in the sanctity of life should be grounds for compulsion of treatment in all cases of religiously motivated refusals, see Comment, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 CALIF. L. REV. 860, 872 & *passim* (1965).

19. 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

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

21. *Id.* *Cf. Dockery v. Dockery*, 559 S.W.2d 952 (Tenn. App. 1977) (A lower court appointing the patient's husband her guardian held his consent necessary to continue the respirator if there were no reasonable possibility that (1) the patient would ever emerge from her coma and (2) the treatment would cure the patient. While the appeal was pending the patient died. The appellate court held the case moot.)

The *Quinlan* court also considered the state's interest in preserving the ethical integrity of the medical profession, and found that medical ethics would not necessarily require saving Quinlan's life. 70 N.J. at 39, 44-48, 355 A.2d at 663, 666-69. See note 16 *supra*, notes 92-95 *infra* and accompanying text.

22. See notes 43-47, 72-76 *infra* and accompanying text. Contrary to all expectations, Quinlan survived removal of the respirator. At this writing she is still alive and unconscious.

23. 156 N.J. Super. 282, 383 A.2d 785 (1978).

24. *Id.* at 290 & n.2, 383 A.2d at 789 & n.2. From the state's viewpoint Quackenbush's prognosis was good because in *Quinlan's* terms, he would retain cognitive, sapient life. The court admitted, however, that from the patient's point of view the prognosis may be poor, because treatment would leave him disabled.

the extensive bodily invasion alone was sufficient to overcome the state's interest in the preservation of life.²⁵

The Supreme Judicial Court of Massachusetts established a different balancing test in *Superintendent of Belchertown v. Saikewicz*.²⁶ The *Saikewicz* court declared that a patient's right to refuse medical treatment outweighed the state's interest in preservation of human life, if the proposed treatment will not cure the patient or save life, but merely "prolong" life, and induces unpleasant side effects as well.²⁷ In *Saikewicz*, the court affirmed a probate court decision to refuse chemotherapy for acute leukemia on behalf of a severely retarded adult.²⁸ The court found that both the common-law right to bodily integrity and the constitutional right to privacy protect a competent patient's right to refuse medical treatment.²⁹ To preserve the incompetent patient's right to refuse, the *Saikewicz* court authorized the probate court to act on the patient's behalf.³⁰

25. *Id.* at 290, 383 A.2d at 789. *Quinlan* left open the possibility of withholding treatment in certain cases "not necessarily involving the hopeless loss of cognitive or sapient life." 70 N.J. at 154 n.10, 355 A.2d at 671 n.10. *Quackenbush*, however, does not seem to be the sort of case contemplated by that footnote.

26. — Mass. —, 370 N.E.2d 417 (1977).

27. The treatment offered no cure for the leukemia, but only a possibility of temporary remission.

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

Id. at —, 370 N.E.2d at 425-26.

The court also considered and disposed of three other state interests. (1) The state's interest in protecting a patient's minor children was irrelevant, because *Saikewicz* had none. *Id.* at —, 370 N.E.2d at 426. (2) The state's interest in protecting the ethical integrity of the medical profession was not endangered, because medical mores recognize the right to refuse treatment in some circumstances. Moreover, the patient's right was "superior to the institutional considerations." *Id.* at —, 370 N.E.2d at 426-27. See notes 92-95 *infra* and accompanying text. (3) The state's interest in suicide prevention was inapplicable here because refusal of treatment is not technically suicide, see note 97 *infra*, and in this court's view, the state's interest in suicide prevention extends only to the "prevention of irrational self destruction." *Id.* at — n.11, 370 N.E.2d at 426 n.11.

At least two cases have allowed competent patients to refuse treatment that would cause suffering and only briefly prolong their lives. *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 48 U.S.L.W. 2503 (Fla., Jan. 17, 1980); *Palm Springs Gen. Hosp., Inc. v. Martinez*, No. 71-12678 (Dade County Cir. Ct. July 2, 1976), *discussed in* Byrn, *supra* note 5, at 13-14.

28. *Id.* at —, 370 N.E.2d at 432-35.

29. *Id.* at —, 370 N.E.2d at 424.

30. *Id.* at —, 370 N.E.2d at 433-34. See notes 43-49, 67-71 *infra* and accompanying text.

Two Massachusetts appellate courts have applied *Saikewicz*.³¹ In *Lane v. Candura*³² the court allowed an elderly patient to refuse to submit to a potentially life-saving amputation. The *Lane* court interpreted *Saikewicz* broadly, as recognizing a competent patient's right to decline treatment "in most circumstances."³³ It abandoned *Saikewicz*'s distinction between life-saving and merely life-prolonging treatment, and found the magnitude of the proposed bodily invasion reason enough to overcome the state's interest in life.³⁴ In *In re Dinnerstein*³⁵ another appellate court held that a decision not to resuscitate an elderly, barely conscious patient in the last stages of a terminal illness is a "medical" decision and needs no prior judicial approval. Although *Saikewicz* had required court approval to withhold life-prolonging medical treatment, resuscitation in this case would not even be life-prolonging, for in this court's view life-prolonging "contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence."³⁶

Each of these cases required, at least implicitly, that the patient's refusal of treatment not harm other parties. In addition, in New Jersey, *Quinlan* required that a refusing patient be faced with an invasive medical procedure along with a dim prognosis for cognitive life; *Quackenbush* required only a significant invasion along with unspecified "other circumstances." In Massachusetts, *Saikewicz* focused on whether the

31. The two cases arose at approximately the same time; neither court cited the other case. See *In re Dinnerstein*, — Mass. App. Ct. —, 380 N.E.2d 134 (1978) (decided June 30, 1978); *Lane v. Candura*, — Mass. App. Ct. —, 376 N.E.2d 1232 (1978) (decided May 26, 1978).

32. — Mass. App. Ct. —, 376 N.E.2d 1232 (1978).

33. *Id.* at —, 376 N.E.2d at 1233. The court dismissed the state's interests in a footnote, concluding that "[t]he magnitude of the invasion proposed in this case is decisive in applying the balancing test." *Id.* at — n.2, 376 N.E.2d at 1233 n.2.

34. *Id.* at — & n.2, 376 N.E.2d at 1233 & n.2.

35. — Mass. App. Ct. —, 380 N.E.2d 134 (1978). The patient's family had joined the doctor and hospital in asking for a declaration that the doctor could enter an order not to resuscitate the patient in the event of cardiac or respiratory failure, and could do so without prior court approval.

Ordering that a dying patient not be resuscitated is not an uncommon medical practice. See, e.g., *Sounding Board—"Code" or "No-Code": A Nonlegal Opinion*, 300 NEW ENG. J. MED. 138, 139 (1979) ("There is general agreement that people who experience sudden death in the setting of good health or a reversible medical condition should be resuscitated, and that patients whose underlying condition is one of rapid and inevitable progression to death should not be resuscitated when that event finally occurs.").

36. *Id.* at —, 380 N.E.2d at 138. Resuscitation could only have restored the patient's essentially vegetative state and would have been a "mere suspension of the act of dying." *Id.*

therapy was unpleasant and merely life-prolonging, but *Lane* allowed refusal where the surgery was potentially life-saving.

B. *The Incompetent Patient*

Courts have developed two methods of handling questions of life-saving treatment for incompetent patients. In many cases, a determination of incompetency³⁷ automatically leads to the court's either ordering treatment or appointing a guardian who, on behalf of the patient, consents to it.³⁸ Included among these cases are elderly patients' attempts to refuse amputations,³⁹ adults' refusals of blood transfusions,⁴⁰ parents' religiously motivated refusals of treatment for their children,⁴¹ and one case of parental refusal to authorize life-saving surgery for a

37. The determination of incompetency is not always a clear-cut process. See *Lane v. Candura*, — Mass. App. Ct. —, 376 N.E.2d 1232, 1233-36 (1978) (probate court found patient's refusal of amputation was not "rational and informed," and appointed guardian to override her refusal; appellate court reversed, holding that patient was aware of the nature and consequences of her decision).

38. These cases do not consider the possibility of a court's or guardian's deciding *against* treatment which may be due to the procedural posture of the cases. They are typically brought under guardianship statutes that provide for a guardian to consent to treatment. *But cf.* *Superintendent of Belchertown v. Saikewicz*, — Mass. —, 370 N.E.2d 417 (1977) (court decides against ordering life-prolonging treatment with unpleasant side effects). See note 27 *supra*.

39. These elderly patients have usually been ill for some time and are often confused. Their refusals of treatment are frequently equivocal. Cases that found the patients incompetent and appointed guardians include *In re Schiller*, 148 N.J. Super. 168, 372 A.2d 360 (1977); *Long Island Jewish-Hillside Med. Center v. Levitt*, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973); *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197 (Tenn. Ct. App. 1978). See *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964) (court ordered life-saving surgery for comatose patient whose wife, for reasons not specified in opinion, had refused authorization and whose own wishes were unknown to court). *But cf. In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1964) (court did not order amputation where its value was disputed by doctors, family's opinion was divided, and patient, though confused, seemed opposed).

40. *In re Georgetown College*, 331 F.2d 1000, 1008 (D.C. Cir.) (that patient was "hardly *compos mentis*" was one ground for ordering treatment), *cert. denied*, 377 U.S. 978 (1964); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) (court said patient was confused and incoherent, but then decided case as if she were competent).

41. *Jehovah's Witnesses v. King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968); *In re Ivey*, 319 So. 2d 53 (Fla. App. 1975); *People v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952); *Morrison v. State*, 252 S.W.2d 97 (Mo. Ct. App. 1952); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751, *cert. denied*, 371 U.S. 890 (1962); *In re Clark*, 21 Ohio Op. 2d 86, 185 N.E.2d 128 (Ohio Comm. Pleas 1962); *Mitchell v. Davis*, 205 S.W.2d 812 (Tex. Civ. App. 1947); *cf. Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (pregnant mother compelled to undergo life-saving transfusions to protect life of unborn child), *cert. denied*, 377 U.S. 985 (1964); *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (1961) (court appointed guardian for child before it was born, to consent to transfusions expected to be neces-

deformed infant.⁴²

*Quinlan*⁴³ and *Saikewicz*⁴⁴ departed from this approach. Rather than automatically ordering life-saving treatment, these cases attempted to consider the wishes of the incompetent patients and grant the rights the patients would have had were they competent. Because *Quinlan*, while competent, had never specified what she would want done were she to someday become dependent on a respirator with little hope of regaining consciousness,⁴⁵ and because *Saikewicz* had never been competent, the courts had no way of knowing their actual wishes. Determined to preserve the patient's right to decide despite the pa-

sary immediately after birth); *People v. Pierson*, 176 N.Y. 201, 68 N.E. 243 (1903) (parents indicted under penal code for failure to seek medical attention for child).

In ordering treatment for these children, courts have relied both on neglect statutes and on the state's traditional authority as *parens patriae*—its right and duty to care for and protect children. See also *Prince v. Massachusetts*, 321 U.S. 158, 165-66, 170 (1944).

Courts have split on the proper approach where the child's life is not immediately threatened. See cases collected in Schultz, Swartz & Appelbaum, *Deciding Right-to-Die Cases Involving Incompetent Patients*: *Jones v. Saikewicz*, 11 SUFFOLK U.L. REV. 936, 938 n.12 (1977).

42. *Maine Medical Center v. Houle*, No. 74-145 (Cumberland County Super. Ct., Me., Feb. 14, 1974), excerpted in WEIR, *ETHICAL ISSUES IN DEATH AND DYING* 185 (1977).

Parents and doctors often hesitate to save the lives of severely defective infants if the underlying defect is incurable. Although *Houle* is the only available case on the issue, one commentator states that courts in these cases respond "almost as a reflex in favor of life." Duff & Campbell, *On Deciding the Care of Severely Handicapped or Dying Persons: With Particular Reference to Infants*, 57 PEDIATRICS 487, 490 (1976). Another commentator, however, claims courts generally refuse to order treatment for severely deformed infants with limited life expectancies. Hirsch & Donovan, *The Right to Die: Medio-Legal Implications of In re Quinlan*, 30 RUTGERS L. REV. 267, 296 (1977). Neither article cites cases supporting these opposing propositions. Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213 (1975), and Robertson & Fost, *Passive Euthanasia of Defective Newborns: A Legal Analysis*, 88 J. PEDIATRICS 883 (1976), argue that there is no legal justification for not treating these infants, and failure to treat them establishes a clear basis for liability of parents and doctors.

A further sampling of the literature on this issue includes: Duff & Campbell, *Moral & Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890 (1973) (landmark report of infants in one hospital allowed to die without necessary surgery); Gustafson, *Mongolism, Parental Desires, and the Right to Life*, 16 PERSPECTIVES IN BIOLOGY & MED. 529 (1973); Horan, *Euthanasia, Medical Treatment & the Mongoloid Child: Death as a Treatment of Choice?*, 27 BAYLOR L. REV. 76 (1975); Shaw & Shaw, *Dilemmas of "Informed Consent" in Children*, 289 NEW ENG. J. MED. 885 (1973); *Medical Ethics: The Right to Survival: Hearing Before the Subcomm. on Health of the Sen. Comm. on Labor & Pub. Welfare*, 93d Cong., 2d Sess. (1974) [hereinafter referred to as *Hearings, Medical Ethics*].

43. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976). See notes 19-22 *supra* and accompanying text.

44. *Superintendent of Belchertown v. Saikewicz*, — Mass. —, 370 N.E.2d 417 (1977). See notes 28-30 *supra* and accompanying text.

45. The court held that under the facts of the case, any prior statements had *Quinlan* made opposing the use of respirators lacked probative value. 70 N.J. at 41-42, 355 A.2d at 664.

tient's inability to exercise that right, the court in each case adopted the principle of "substituted judgment," which allows other parties to make and execute the decision the patient might have made.⁴⁶ Appointing the patient's father as her guardian, the *Quinlan* court held that he might terminate treatment would she have done so herself.⁴⁷ The *Saikewicz* court held that the "substituted judgment" decision must be made by a probate court,⁴⁸ and it approved the probate court's decision that Saikewicz would have refused treatment even though most competent patients would choose to undergo the chemotherapy.⁴⁹

III. THE PATIENT'S RIGHT TO REFUSE LIFE-SAVING MEDICAL TREATMENT

Neither the common law nor the Constitution explicitly recognizes a right to refuse life-saving medical treatment,⁵⁰ and statutory protection is severely limited.⁵¹ In the absence of an explicit right to refuse, the medical treatment cases have turned to the first amendment, the consti-

46. A decision made by "substituted judgment" is distinguished from one made in the "best interests of the patient," though both may reach the same conclusion. See Cantor, *supra* note 4, at 258-59.

For an argument of the impropriety of the use of "substituted judgment" to make treatment decisions on behalf of incompetent patients, see Schultz, Swartz & Appelbaum, *supra* note 41, at 943-47. For a counterargument, see Brant, *The Right to Die in Peace: Substituted Consent & the Mentally Incompetent*, 11 SUFFOLK U.L. REV. 959, 972 (1977).

47. 70 N.J. at 41-42, 44, 355 A.2d at 664, 666. The father was required to consult with the rest of the family, and with a hospital ethics committee whose role is unclear. Compare *id.* at 54, 355 A.2d at 671 (committee merely confirms doctor's opinion of no reasonable chance for return of consciousness), with *id.* at 49-50, 355 A.2d at 668-69 (indicates committee has a broader role).

48. — Mass. at —, —, 370 N.E.2d at 429-31, 434-35. The court's decision must meet strict procedural safeguards including the provision of a guardian *ad litem* who must argue *for* treatment. *Id.* at —, 370 N.E.2d at 432-34.

49. *Id.* at —, 370 N.E.2d at 432. The court believed that he would have refused because his inability to understand the cause of the unpleasant side effects and the necessity of physically restraining him to administer the treatment would have caused him to suffer more than a competent patient. Treatment would have resulted in a painful and incomprehensible disruption of his secure environment. Moreover, the chemotherapy was less successful in patients his age.

50. The Constitution does, however, explicitly protect an individual's interest in preserving life. The fifth amendment provides that "[n]o person shall . . . be deprived of life . . . without due process of law"; the fourteenth amendment affords the same protection from the state.

The common law right to bodily integrity is not clearly available as protection for a choice resulting in death. See notes 68-70 *infra* and accompanying text.

51. Only eight states (Arkansas, California, Idaho, Nevada, New Mexico, North Carolina, Oregon, and Texas) have enacted "natural death" or "living will" statutes permitting individuals to order no further life-saving medical treatment should certain circumstances arise in the future. Most apply only to a patient with a terminal illness. Only one allows someone else to execute such a document on behalf of an incompetent patient. See Horan, *The "Right to Die"—Legislative &*

tutional right of privacy, and the common-law right of bodily integrity as legal bases for this right.

A. *Freedom of Religion, the Right to Privacy, and the Competent Patient*

Arguably, there are two constitutional sources that protect a competent patient's right to refuse life-saving medical treatment and limit the state's right to interfere with the patient's decision.⁵² The first is the first amendment's guarantee of freedom of religion,⁵³ which is commonly raised by patients who refuse blood transfusions. Although the

Judicial Developments, 13 FORUM 488 (1978); SOCIETY FOR THE RIGHT TO DIE, LEGISLATIVE MANUAL 1978. No case discussed in this Note involved this kind of statute.

52. These constitutional provisions would protect patients only from state action that infringes upon their right to refuse. Because there is no constitutional issue between a patient and a private hospital or physician without state involvement, some commentators suggest that all hospitals are necessarily involved in state action. Cantor, *supra* note 15, at 229 n.4; Sanders & Dukeminier, *Medical Advance & Legal Lag: Hemodialysis & Kidney Transplantation*, 15 U.C.L.A. L. REV. 357, 373 (1968). The courts, however, have developed a restrictive test that must be satisfied before hospitals are considered to be acting under color of state law. Receipt of government funds, coupled with state participation in the infringement of the asserted right is necessary to fulfill the state action requirement.

The fact that [the state] regulates "facilities and standards of care of private hospitals or offers them financial support does not make the acts of these hospitals in discharging physicians the acts of the state." *Mulvihill v. Julia L. Butterfield Memorial Hospital*, 329 F. Supp. 1020, 1023 (S.D.N.Y. 1971). Such a rule would overlook the "essential point—that the state must be involved not simply with some activity of the institution alleged to have inflicted injury upon a plaintiff but with the activity that caused the injury. Putting the point another way, the state action, not the private action, must be the subject of complaint." *Powe v. Miles*, 407 F.2d 73, 81 (2d Cir. 1968).

Ward v. St. Anthony Hosp., 476 F.2d 671, 675 (10th Cir. 1973). Only one medical treatment case discussed the state action requirement. See *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125, 132-33 (N.D. Ill. 1972). The holding in *Holmes* was subsequently narrowed in *Johnson v. Household Vin. Corp.*, 453 F. Supp. 1327, 1332 (S.D. Ill. 1978).

State action may be necessarily involved in any judicial decision, regardless of the private nature of the underlying transaction. See *Shelly v. Kraemer*, 334 U.S. 1 (1947) (judicial enforcement of racially restrictive covenant would be unconstitutional state action). Finally, insofar as state law influences the doctor's and hospital's insistence on administering treatment, courts may find state action. Cf. *Reitman v. Mulkey*, 387 U.S. 369 (1967) (state constitutional provision that was otherwise unobjectionable held to violate fourteenth amendment equal protection if purpose and effect was to encourage discrimination). In the medical treatment cases the significant state law may be the homicide law, or state statutory or common law requirements of standards of medical practice.

53. The first amendment prohibits Congress from making any "law respecting an establishment of religion, or prohibiting the free exercise thereof." U.S. CONST. amend. I. This prohibition applies to the states through the fourteenth amendment. *Cantwell v. Connecticut*, 310 U.S. 296, 303 (1940). But see *In re Quinlan*, 70 N.J. 10, 35-37, 355 A.2d 647, 661-62 (The claim may be asserted only on one's own behalf. A parent's first amendment claim can never justify withhold-

Supreme Court has denied total immunity to religiously motivated behavior,⁵⁴ the states may restrict the "fundamental right" to freedom of religion only to effectuate a "compelling" state interest.⁵⁵ Several of the transfusion cases totally ignore the first amendment issues,⁵⁶ while others attempt to apply the Supreme Court's test and balance the asserted state interest against the patient's right to freedom of religion.⁵⁷

The right of privacy, an aspect of the "liberty" guaranteed by the fourteenth amendment,⁵⁸ provides the second possible constitutional basis for refusing life-saving medical treatment.⁵⁹ Like the right to

ing life-saving treatment from a child), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976); 41 *supra* and accompanying text.

54. Reynolds v. United States, 98 U.S. 145 (1878) (religious belief is immune from state regulation, but conduct in pursuit of religious belief may be regulated).

55. Wisconsin v. Yoder, 406 U.S. 205, 214 (1972); Sherbert v. Verner, 374 U.S. 398, 403, 406 (1963).

Some of the older free-exercise cases were closely related to free-speech claims, and applied the "clear and present danger" test. *See* Schenk v. United States, 249 U.S. 47, 52 (1918). *See also* West Virginia Bd. of Educ. v. Barnette, 319 U.S. 624, 633 (1943); Cantwell v. Connecticut, 310 U.S. 296, 311 (1940).

56. *See, e.g., In re Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *Raleigh Fitkin-Paul Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964); *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

57. *See, e.g., Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125, 129-30 (N.D. Ill. 1972) (applied clear and present danger test); *In re Osborne*, 294 A.2d 372, 374-75 (D.C. 1972) (applied compelling state interest test); *In re Brooks*, 32 Ill. 2d 361, 373, 205 N.E.2d 435, 442 (1965) (applied clear and present danger test); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 584, 279 A.2d 670, 674 (1971) (applied compelling state interest test); *In re Melideo*, 88 Misc. 2d 974, 975, 390 N.Y.S.2d 523, 524 (Sup. Ct. 1976) (applied compelling state interest test). Although the courts may use different terminology, the balancing process is similar in all cases.

58. *See Roe v. Wade*, 410 U.S. 113, 153 (1973). *See generally* Cantor, *supra* note 4, at 245; Henkin, *Privacy & Autonomy*, 74 COLUM. L. REV. 1410 (1974).

59. The Supreme Court has held the right to privacy includes the following rights: (1) contraception, *Carey v. Population Serv. Int'l*, 431 U.S. 678 (1977) (rights of persons under 16); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (rights of unmarried persons); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (rights of married couples); (2) abortion, *Roe v. Wade*, 410 U.S. 113 (1973); (3) choice of education for one's child, *Runyon v. McCrary*, 427 U.S. 160 (1976); *see Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923); (4) possession of obscene material in one's home, *Stanley v. Georgia*, 394 U.S. 557 (1969).

There are other fundamental rights entitled to special protection. *See Zablocki v. Redhail*, 434 U.S. 374 (1978) (statute prohibiting parent with support obligations to child not in his custody from marrying without court approval violates equal protection clause); *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (choice of number of non-nuclear family members in household); *Stanley v. Illinois*, 405 U.S. 645 (1972) (unwed father's right to custody hearing after death of child's mother recognizes right of maintenance of parent-child relationship); *Loving v. Virginia*, 388 U.S. 1 (1967) (anti-miscegenation statute is unconstitutional deprivation of liberty); *Skinner v.*

freedom of religion, the right to privacy is a "fundamental" one; although not absolute, it can be restricted only to achieve a "compelling" state interest.⁶⁰ The recent medical-treatment cases have held that the right to privacy protects a patient's right to refuse life-saving medical treatment.⁶¹ Because the Supreme Court has never fully clarified the meaning of privacy,⁶² it is not immediately apparent that these cases were correctly decided. Analysis of common factors in the privacy cases is, therefore, necessary to decide whether the right to refuse life-saving medical treatment indeed involves the right of privacy.⁶³

Insistence on the right to independence and autonomy in deciding one's fate is a common element of the privacy cases.⁶⁴ To be consid-

Oklahoma, 316 U.S. 535 (1942) (law providing for sterilization of some criminals violates equal protection clause in light of procreation right).

The Court has left open the question of privacy rights in certain activities. See *Kelley v. Johnson*, 425 U.S. 238 (1976) (dicta) (a private citizen's choice of personal appearance). Compare *Paul v. Davis*, 424 U.S. 693 (1976), and Justice Stewart's concurring opinion in *Whalen v. Roe*, 429 U.S. 589 (1977), with Justice Stevens' majority opinion and Justice Brennan's concurring opinion in *Whalen* concerning prevention of information disclosure.

The right of privacy does not cover certain activities. See *Kelley v. Johnson*, 425 U.S. 238 (1976) (policeman's choice of personal appearance); *Village of Belle Terre v. Boraas*, 416 U.S. 1 (1974) (choice of number of unrelated persons in household); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49 (1973) (watching obscene movies in places of public accommodation); *Doe v. Commonwealth's Attorney*, 403 F. Supp. 1199 (E.D. Va. 1975) (engaging in homosexual acts), *aff'd mem.*, 425 U.S. 901 (1976).

60. See, e.g., *Moore v. City of East Cleveland*, 431 U.S. 494, 499 (1977); *Whalen v. Roe*, 429 U.S. 589, 607 (1977) (Brennan, J., concurring); *Roe v. Wade*, 410 U.S. 113, 155 (1973); *Henkin, supra* note 58, at 1421, 1426. See notes 82-133 *infra* for a discussion of the state's interests.

61. *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978) (court limits holding to right of a competent adult patient to refuse treatment), *aff'd*, 48 U.S.L.W. 2503 (Fla., Jan. 17, 1980); *Superintendent of Belchertown v. Saikewicz*, — Mass. —, —, 370 N.E.2d 417, 431-32 (1977) (patient may refuse treatment that induces unpleasant side effects and merely "prolongs" life); *In re Quinlan*, 70 N.J. 10, 38-42, 355 A.2d 647, 663-64 (1976) (degree of bodily invasion allowed individual right of privacy to prevail); *In re Quackenbush*, 156 N.J. Super. 282, 288-90, 383 A.2d 785, 789 (1978) (extensive bodily invasion sufficient to make state's interest in preservation of life give way to patient right of privacy); *In re Yetter*, 62 Pa. D. & C.2d 619, 624 (1973) (court will not interfere with the right of a competent individual even if the decision to avoid treatment "might be considered unwise, foolish, or ridiculous").

62. The Court often lists "marriage, procreation, contraception, family relationships, child rearing, and education," as privacy rights, implying that all privacy rights must be related to these. See, e.g., *Whalen v. Roe*, 429 U.S. 589, 600 n.26 (1977); *Paul v. Davis*, 424 U.S. 693, 713 (1976); *Roe v. Wade*, 410 U.S. 113, 152-53 (1973). This approach, however, does not adequately explain what privacy encompasses for their seems to be no unifying factor to the items on the list.

63. This analysis focuses only on the "right to refuse life-saving medical treatment," rather than the broader "right to die" or the narrower "right to reject extraordinary medical treatment."

64. See, e.g., *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977) (privacy protects the right to make "certain kinds of important decisions"); *Paul v. Davis*, 424 U.S. 693, 713 (1976) (privacy protects

ered a privacy right, however, the decision to refuse life-saving medical treatment must involve a fundamental right. These specially protected decisions appear to fall into two categories. First, the Court protects decisions that are of fundamental importance to the decision-maker.⁶⁵ Refusal of life-saving medical treatment clearly meets this criterion, for few decisions could spring from more deeply held convictions or have a more profound impact on one's future. Second, the Court shows special concern for "basic values that underlie our society"⁶⁶ and for institutions that are "deeply rooted in our history and tradition."⁶⁷ Although the common-law rights to control one's body⁶⁸ and to consent to or refuse medical treatment⁶⁹ are "basic, deeply rooted values," the right to choose a medical course of action resulting in or hastening

"freedom of action in a sphere contended to be 'private'"; *Roe v. Wade*, 410 U.S. 113, 153 (1973) (privacy allows a woman to choose to terminate a pregnancy, lest she be forced to face the possibility of medical or psychological harm, or a distressful future); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right . . . to be free from unwarranted government intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."). See generally Henkin, *supra* note 58. The right to make a decision was involved in all of the privacy and other fundamental liberty cases, note 59 *supra*, although not all of the cases relied on it.

65. See, e.g., *Roe v. Wade*, 410 U.S. 113, 153 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972). See generally Delgado, *Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474, 477 (1975); Note, *Roe & Paris: Does Privacy Have a Principle?*, 26 STAN. L. REV. 1161, 1175 (1974) (the right of privacy looks to the "impact of the denial of privacy protection on the life of the individual claimant.").

66. *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977). See *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) (privacy protects personal rights that are "fundamental" or "implicit in the concept of ordered liberty"). See also *Kelley v. Johnson*, 425 U.S. 238, 244 (1976); *Paul v. Davis*, 424 U.S. 693, 713 (1976); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 66 (1973); *Roe v. Wade*, 410 U.S. 113, 152 (1973); *Loving v. Virginia*, 388 U.S. 1, 12 (1967); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

67. *Moore v. City of East Cleveland*, 431 U.S. 494, 502 (1977).

68. "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." *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891).

But see *Roe v. Wade*, 410 U.S. 113, 154 (1973) (the right to control one's body is not identical with the constitutional right of privacy, and is not unlimited). See generally W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 804, 807-09 (4th ed. 1971) (intrusion into one's physical solitude may give rise to tort damages in states that recognize the right of privacy); Note, *Suicide & the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases*, 44 BROOKLYN L. REV. 285, 287-90 (1978) (relationship between common-law and constitutional privacy).

69. See *Natanson v. Kline*, 186 Kan. 393, 406-07, 350 P.2d 1093, 1104 (1960) (the requirement of "informed consent" to medical treatment stems from the general common law respect for bodily integrity); *Schloendorff v. Society of the N.Y. Hosp.*, 211 N.Y. 125, ___, 105 N.E. 92, 93 (1914) (treatment without consent may constitute a battery). See also cases cited by Byrn, *supra* note 5, at 5 n.21.

death is not.⁷⁰ Thus, to find that privacy protects a decision to refuse life-saving medical treatment, a court must focus on the patient's interest in bodily control and medical decision-making, rather than on the patient's interest in choosing death. Such an emphasis seems appropriate. The patient's primary desire is to be left in peace. It is this wish, protected by our "basic values", rather than a specific desire to die, that motivates the decision to refuse treatment.⁷¹

B. *Bodily Integrity and the Incompetent Patient*

If the right to privacy indeed protects the decision to decline life-saving medical treatment, courts should honor a choice competently made, even if the patient later becomes incompetent.⁷² No such constitutional right is involved, however, if the patient has never been competent or, while competent did not choose to refuse treatment. The right to privacy is a right to choose,⁷³ and can belong only to a person competent to exercise that right. The *Quinlan* and *Saikewicz* courts were wrong in extending the right to privacy to permit a guardian to choose for a patient who could not.⁷⁴ The *Quinlan* court's fear that the patient's right to privacy would be destroyed lest her guardian assert it⁷⁵ is not persuasive. The time for asserting the right, like the right to execute a will or to vote, simply expires when the patient can no longer exercise it. *Saikewicz*'s concern that incompetent persons have the same rights as competent ones⁷⁶ is similarly misguided, particularly in cases in which the cause of the incompetency makes exercise of the right impossible.

Other rights, though not of constitutional dimension, may be avail-

70. See notes 5-8 *supra* and accompanying text.

71. See Superintendent of Belchertown v. Saikewicz, — Mass. —, — n.11, 370 N.E.2d 417, 426 n.11 (1977) (a competent rational decision to refuse treatment does not require consideration of the state's interest in suicide prevention). See also note 97 *infra*.

72. See, e.g., Cantor, *supra* note 4, at 252; Note, *An Adult's Right to Resist Blood Transfusions: A View through John F. Kennedy Mem. Hosp. v. Heston*, 47 NOTRE DAME LAW, 571, 586-87 (1972). Individuals may make their views known formally, e.g., by a "living will," or informally by telling relatives, friends, and doctors. See also note 51 *supra* for statutory authorization of "living wills."

73. See note 64 *supra* and accompanying text.

74. See L. TRIBE, AMERICAN CONSTITUTIONAL LAW 936 & n.11 (1978); Cantor, *supra* note 4, at 252; Schultz, Swartz & Appelbaum, *supra* note 41, at 956; Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U.L. REV. 285, 294-99 (1976).

75. 70 N.J. at 41, 355 A.2d at 664.

76. — Mass. at —, 370 N.E.2d at 428.

able to incompetent patients. The right to bodily integrity involves the right to make decisions affecting one's body⁷⁷ but also reflects a concern for avoidance of pain and indignity.⁷⁸ Many believe that much of modern medical technology strips the patient of all human dignity, and that when treatment offers no real benefit⁷⁹ a patient should not be subjected to it.⁸⁰ Conscious but incompetent patients should be able to avoid medical treatment that causes pain or indignity without countervailing benefit. Although unconscious patients sense neither pain nor indignity, the right to bodily integrity should also extend to them, to protect competent persons' interests in assurance of proper treatment, should they become incompetent.⁸¹

Because of the absence of an interest in decision-making, an incompetent patient's right to avoid treatment is not a fundamental constitutional liberty. Although a less than compelling state interest might, therefore, justify infringement of the incompetent patient's right, a court must still scrutinize the asserted state interest and balance the interests of both the state and the patient.

IV. THE STATE'S INTEREST IN LIFE-SAVING MEDICAL TREATMENT

To compel treatment, the state must assert an interest that outweighs the individual's constitutional or common-law right to refuse. The courts have identified the protection of the patient's dependent children, the protection of the interests of the medical profession, and the preservation of life as valid state interests favoring compulsory life-saving medical treatment.⁸²

A. *The Support of Dependents*

Several cases have shown respect for the state's interest in ensuring

77. See notes 68-69 *supra* and accompanying text.

78. L. TRIBE, *supra* note 74, at 914.

79. Cantor, *supra* note 4, at 256.

Our legal system shows concern for the proper treatment of dead bodies. See, e.g., 22 AM. JUR. 2d *Dead Bodies* § 6 (1965); Hellerstein, "Body-Snatching" Reconsidered: *The Exhumation of Some Early American Legal History*, 39 BROOKLYN L. REV. 350 (1972); Note, *The Sale of Human Body Parts*, 72 MICH. L. REV. 1182, 1246-47 (1974). Surely living but unconscious or incompetent persons should also be treated with respect.

80. This viewpoint assumes that continued breathing offers no benefit to a patient who has no hope of regaining consciousness. See Cantor, *supra* note 4, at 257.

81. The treatment decision could still be made by a court or guardian using substituted judgment.

82. See notes 12-33 *supra* and accompanying text.

parental support of minor children.⁸³ The cases go too far, however, by allowing this interest to override a patient's refusal of life-saving medical treatment.⁸⁴ First, only rarely would refusal of treatment leave a child without support.⁸⁵ The economic burden to the state is insufficient to justify deprivation of the patient's right. Second, states do not ordinarily force individuals to fulfill their obligations; rather, states force individuals to suffer the legal consequences of nonfulfillment.⁸⁶ The state does not escort a parent to work to ensure child support; how, then, can a court justify forcing an unwilling patient to stay alive in order to achieve the same goal? Finally, the "ultimate sanction" for child abandonment is court-ordered termination of parental rights.⁸⁷ In refusing treatment, the parent is simply applying this ultimate sanction against himself or herself.⁸⁸

B. *The Interests of the Medical Profession*

Although some courts⁸⁹ have shown concern for protecting the interests of the medical profession, this state interest cannot override a patient's right to refuse treatment. The state may have a valid interest in protecting doctors from civil or criminal liability.⁹⁰ However, civil liability for failing to preserve life is unlikely in cases in which a competent patient, with the family's agreement, signs a waiver of responsibility. Criminal liability would serve little purpose and there-

83. See cases cited note 14 *supra*. Civil and criminal statutes in all states enforce this interest. H. CLARK, *LAW OF DOMESTIC RELATIONS* 187-88, 200, 573 (1968). It is a particular aspect of the state's interest in minimizing the number of public wards. See Cantor, *supra* note 15, at 251-54; Delgado, *supra* note 65, at 491-92.

84. See cases cited note 14 *supra*. See also *Swann v. Pack*, 527 S.W.2d 99 (Tenn.) (state's interest in guarding against "the unnecessary creation of widows and orphans" justifies forbidding snake-handling as a religious practice), *cert. denied*, 424 U.S. 954 (1976).

85. Even if treated, many patients would never be well enough to go back to work and support their children. In cases in which full recovery would be possible, there are often other family members willing and able to assume the support obligation, or sufficient savings or insurance to support the child. Compare *In re Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964), which did not consider these factors, with *In re Osborne*, 294 A.2d 372 (D.C. 1972), which did. See also note 14 *supra*.

86. That the deceased patient in this instance will evade all legal consequences does not justify departure from ordinary legal principles. Many "offenders" evade justice.

87. H. CLARK, *supra* note 83, at 574, 629-30.

88. Parents may voluntarily terminate their own rights and obligations. H. CLARK, *supra* note 83, at 620.

89. See notes 15-16 *supra* and accompanying text.

90. See note 15 *supra* and accompanying text.

fore poses an insignificant threat.⁹¹ Liability is thus a real concern only in the case of an incompetent patient whose own views are unknown and who would recover if treated. In these cases, absent a valid "substituted judgment" decision against treatment, surely the doctor should act on the side of life.

Similarly, the state's interest in protecting the ethical integrity of the medical profession cannot justify compulsory medical treatment.⁹² In actual practice, doctors do not always administer life-saving treatment to incurable or unwilling patients,⁹³ nor do medical ethics require such treatment in all cases.⁹⁴ Even if doctors were committed to preserving life under any circumstances, surely the patient's right to autonomous decision-making would outweigh the threat to the doctor's good conscience.⁹⁵

C. *The Preservation of Life*

The state has a clear interest in preserving the lives of those who want to live.⁹⁶ In the compulsory treatment cases, the state asserted the same interest for persons who did not want to live.⁹⁷ Investigation of

91. *Quinlan* held that because the doctor's action would be necessary to effectuate the patient's constitutional right of privacy, there would be no criminal liability for terminating treatment. 70 N.J. at 52, 355 A.2d at 670.

Several writers have commented on the remoteness of either civil or criminal liability where a competent or incompetent patient could not fully recover even if treated, and the family agrees to withhold treatment. *E.g.*, Collester, *Death, Dying & the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304, 310-12 nn.24-26, 313 n.35 (1977); Horan, *supra* note 51, at 490; *Say Case Law Lacking in Right-to-Die Issues*, 65 A.B.A.J. 1164, 1165 (1979).

92. *See* note 16 *supra* and accompanying text.

93. For studies of physicians' actual practices see D. CRANE, *supra* note 3, and studies cited by Hirsch & Donovan, *supra* note 42, at 268-69 n.10.

94. One noted physician stated that the role of the doctor is to preserve the patient's autonomy, not necessarily to preserve life. *Symposium: Is There a Right to Die?*, 12 COLUM. J. OF LAW & SOC. PROB. 489, 505-06 (1976) (statement of Dr. Eric J. Cassell). *See* cases cited note 16 *supra*.

95. *See* Superintendent of Belchertown v. Saikewicz, — Mass.—, —, 370 N.E.2d 417, 427 (1977) (the physician's interest is trivial compared to the patient's); 64 MICH. L. REV. 554, 558-59 (1966) (state's interest in canons of ethics of a profession is less than its interest in protection of individual liberties).

96. The Declaration of Independence reflects the view that protecting life is a primary purpose of government, and protecting life remains a major state function. Although the fifth and fourteenth amendments do not explicitly require protection of life, they forbid federal or state deprivation of life without due process of law.

97. The state interest asserted here is similar to the interest in suicide-prevention, *i.e.*, the preservation of a life that does not want to be preserved. The courts have contributed little to an understanding of the state's interest in preserving unwilling lives. Suicide is condemned, but without explanation. *See, e.g.*, Wallace v. State, 232 Ind. 700, 701, 116 N.E.2d 100, 100 (1953) ("Self-

this asserted state interest is essential to determine whether it can outweigh a patient's right to refuse treatment.⁹⁸ The state grounds its interest in preserving the lives of the unwilling on the following concerns: religious beliefs,⁹⁹ enforcement of an existing moral code,¹⁰⁰ promotion of a new moral code,¹⁰¹ avoidance of a "slippery slope" that would endanger lives of those who do want to live,¹⁰² maintenance of population and productivity,¹⁰³ and protection of patients from their own hasty or mistaken actions.¹⁰⁴

The Christian view of suicide as sinful, unnatural, and against God's right to end life has had a strong influence on Western thought.¹⁰⁵ Nevertheless, although religions may condemn refusal of life-saving medical treatment,¹⁰⁶ the Constitution specifically prohibits the state

destruction is against the law of God and man."); *May v. Pennell*, 101 Me. 516, 64 A. 885 (1906) (suicide is "ethically reprehensible and inconsistent with the public welfare"); *Commonwealth v. Mink*, 123 Mass. 422 (1877) (suicide is *malum in se*, though not a crime). Therefore any analysis of the state's interest in suicide prevention in general, or compulsory medical treatment in particular, must rely heavily on commentators and independent analysis.

Although the asserted state interest may be the same, refusal of life-saving medical treatment is not technically suicide, because the patient lacks the requisite specific intent, and because death results from natural causes. *Superintendent of Belchertown v. Saikewicz*, — Mass. —, — n.11, 370 N.E.2d 417, 426 n.11 (1977). See *Byrn*, *supra* note 5, at 17-18; *Cantor*, *supra* note 15, at 255, 258; Note, *supra* note 68. See also *In re Georgetown College*, 331 F.2d 1000, 1009 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978), *aff'd*, 48 U.S.L.W. 2503 (Fla., Jan. 17, 1980); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 581-82, 279 A.2d 670, 672-73 (1971).

98. A court may not accept a "sweeping claim" of state interest if a fundamental liberty is at stake. Rather, it must make a "searching inquiry" into the threatened state interest and into the manner and extent that allowing the individual liberty endangers that state interest. *Wisconsin v. Yoder*, 406 U.S. 205, 221 (1972); see *Roe v. Wade*, 410 U.S. 113, 155 (1973); *Sherbert v. Verner*, 374 U.S. 398, 403, 406 (1963). In failing to explicate the state's interest, see note 97 *supra*, the courts have ignored the "searching inquiry" mandated by *Yoder*.

99. See notes 105-07 *infra* and accompanying text.

100. See notes 108-11 *infra* and accompanying text.

101. See notes 112-15 *infra* and accompanying text.

102. See notes 116-17 *infra* and accompanying text.

103. See notes 121-25 *infra* and accompanying text.

104. See notes 126-33 *infra* and accompanying text.

105. Blackstone said one who commits suicide is guilty of a spiritual offense, "in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for." 4 W. BLACKSTONE, COMMENTARIES *189. Augustine viewed suicide as a violation of "Thou shalt not kill." See generally N. ST. JOHN-STEVAS, *supra* note 5, at 248.

106. Religious insistence of the preservation of life does not necessarily apply to every treatment situation. Some religions require refusal of life-saving transfusions; others rely on faith-healing. The Catholic Church does not require the use of "extraordinary means of preserving life." 70 N.J. at 30-33, 355 A.2d at 658-59.

from enforcing religious beliefs.¹⁰⁷

The state has an interest in enforcing a communal moral code,¹⁰⁸ but this interest alone is an unconvincing justification for compulsory treatment. If our moral code were absolutely committed to protecting and preserving life, this state interest might justify compulsory medical treatment. The searching inquiry necessary to validate a compelling state interest¹⁰⁹ shows, however, that our moral code is not so committed, and reveals numerous examples of the state's failure to protect life as well as its willingness to expend life for the good of the state.¹¹⁰ In fact, community sentiment, depending upon the particular circumstances, often condemns prolonging life.¹¹¹ Thus, the state's interest in enforcing morality cannot outweigh a refusal of life-saving medical treatment.

If the state cannot claim a compelling interest in enforcing an existing pro-life morality, perhaps it has an interest in promoting the de-

107. The first amendment, applicable to the states through the fourteenth amendment, forbids laws regarding an establishment of religion. See note 53 *supra*.

108. This interest is frequently expressed in legislation concerning "victimless crimes." See, e.g., Byrn, *supra* note 5, at 20; Cantor, *supra* note 15, at 245. Polygamy is a frequently cited example of such a law. Reynolds v. United States, 98 U.S. 145 (1878). Homosexuality and prostitution are contemporary examples.

Lord Patrick Devlin argues that a common morality is as essential to the preservation of society as is its political structure. Devlin, *Morals & the Criminal Law*, in MORALITY & THE LAW 32, 36 (R. Wasserstrom ed. 1971). H.L.A. Hart responds that not "everything to which the moral vetoes of accepted morality attach is of equal importance" to the preservation of society, and adds that many things the common person finds "intolerable" are based on prejudice, ignorance, fear, or superstition. H.L.A. Hart, *Immorality & Treason*, in MORALITY & THE LAW 52, 53-54 (R. Wasserstrom ed. 1971).

109. See note 98 *supra*.

110. Our society allows and even requires the taking of life in a "good cause," as in war or capital punishment. We allow lives to be lost for the sake of convenience or slight economic gain. Calabresi, *The Decision for Accidents: An Approach to Nonfault Allocation of Costs*, 78 HARV. L. REV. 713, 716 (1965) (citing examples such as building a tunnel that is expected to cost the life of one worker per kilometer, or using unsafe methods of travel and equipment); Note, *Informed Consent & the Dying Patient*, 83 YALE L.J. 1632, 1647 (1974) (citing speed limits set at levels known to be unsafe). Another example occurs every winter, when persons, unable to pay their utility bills, occasionally freeze to death. We do not impose criminal or tort liability for mere failure to save a stranger's life. W. LAFAVE & A. SCOTT, *supra* note 5, at 183; W. PROSSER, *supra* note 68, at 340-41.

111. See, e.g., *Death with Dignity: Hearings Before the Special Sen. Comm. on Aging*, 92d Cong., 2d Sess. (1972) [hereinafter referred to as *Hearings, Death with Dignity*]; *Moral, Ethical, & Legal Questions of Extraordinary Health Care: Hearings Before the Subcomm. on Health of the Sen. Comm. on Labor & Pub. Welfare*, 94th Cong., 1st Sess. (1975) [hereinafter referred to as *Hearings, Moral Questions*]. Colletter, *supra* note 91, cites examples of public sympathy for active euthanasia.

velopment of such a morality¹¹² and in encouraging a belief that all life is sacred.¹¹³ Because it is doubtful that allowing a competent patient to refuse medical treatment would significantly affect popular concepts of the sanctity of life,¹¹⁴ this interest is not compelling enough to outweigh a competent patient's constitutionally protected right to refuse. It might, however, outweigh an incompetent patient's common-law right to avoid treatment. The difference in circumstances is significant, for failure to treat patients who are incapable of expressing a choice may encourage a belief that the lives of the helpless are worthless. The proper approach in such cases, after a third party has made a "substituted judgment" decision against treatment, is a test that balances the evidence of the state's interest in promoting respect for life and the impact of non-treatment on the state's interest against the degree of harm that treatment would cause the incompetent patient.¹¹⁵

Many commentators argue that line drawing is impossible,¹¹⁶ and that to permit willing patients to die will inevitably lead to forcing death upon unwilling ones.¹¹⁷ A state would clearly have a compelling

112. The promotion of values is a permissible and possibly a compelling state interest. Cantor, *supra* note 4, at 250; *Project—Education & the Law: State Interests & Individual Rights*, 74 MICH. L. REV. 1373, 1394-95 (1976) (socialization to common values is one state interest that justifies compulsory education laws).

113. The state may believe that this attitude is desirable in itself, or perhaps for some more practical reason, for example, greater societal reverence for life might decrease homicides. *See, e.g.*, Byrn, *supra* note 5, at 20-21; Cantor, *supra* note 15, at 243-44; Delgado, *supra* note 65, at 482, 488-89.

114. Any erosion of public respect for the sanctity of life caused by permitting refusals of treatment "would appear miniscule when compared to that resulting from other sources." Delgado, *supra* note 65, at 489. Moreover, decisions to allow such refusals are motivated by, and arguably would encourage, respect for the individual rather than disregard for life. *See* Superintendent of Belchertown v. Saikewicz, — Mass. —, —, 370 N.E.2d 417, 426 (1977) ("The value of life . . . is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.").

115. Application of this test might have resulted in an order to continue treating Quinlan. Because she was unconscious, treatment could not harm her. However, the court might have allowed termination on the grounds that it would not diminish popular respect for the value of life.

Had *Saikewicz* applied this test, the court might have balanced the harm treatment would cause him against the possibility that the public would view failure to administer treatment as a denigration of the value of a retarded person's life.

116. Logicians use the term "slippery slope" to identify the problems of making distinctions and drawing lines. For examples of its use in euthanasia discussions, see Cantor, *supra* note 4, at 264-65; Colleser, *supra* note 91, at 327; Robertson, *supra* note 42, at 265; Robertson & Fost, *supra* note 42, at 887.

117. Kamisar fears voluntary euthanasia is an "opening wedge" that may lead to killing off the retarded, the insane, and the senile. He cites the example of Nazi Germany. Kamisar, *Some*

interest in avoiding a "slippery slope," if, indeed, there is one. There is, however, no "slippery slope" problem in instances in which a competent patient refuses treatment. Withholding treatment from one patient, in response to the express wishes of that patient, simply cannot establish a precedent for withholding treatment from another patient who wants treatment. The "slippery slope" argument, however, is of greater significance in cases involving patients incompetent to express their own desires. The doctrine of "substituted judgment" does not solve this problem. It is too easy to convince oneself and a court that a retarded, handicapped, or elderly patient would prefer death to life, and too difficult to know what the patient would really choose.¹¹⁸ It is possible, however, when dealing with incompetent patients, to set standards that limit the opportunities for abuse and give full recognition to the needs of both the individual patient and the state. Limitations such as the following would seem appropriate: life-saving treatment may be withheld under proper circumstances, but no patient may be actively put to death;¹¹⁹ substituted judgment may authorize withholding treatment only if the treatment would harm the patient¹²⁰ or if it would restore conscious life.

Non-Religious Views Against Proposed "Mercy Killing" Legislation, 42 MINN. L. REV. 969, 1031-41 (1958). Cantor asks if *Quinlan*, a passive euthanasia case, will result in wholesale elimination of defective newborns, mental retardates, senile persons, and other handicapped individuals. Cantor, *supra* note 4, at 264-65. See N. ST. JOHN-STEVAS, *THE RIGHT TO LIFE* (1963) (once the principle of the sanctity of life is abandoned, there can be no definition of the right to life save that which is dependent on personal taste.), cited in Comment, *supra* note 18, at 862.

118. Several commentators have pointed out the dangers of allowing a proxy's judgment about a handicapped, senile, deranged or retarded person would prefer to be dead; e.g., *Hearings, Medical Ethics*, *supra* note 42, at 15 (statement of Dr. Robert E. Cooke); Robertson, *supra* note 42, at 254; cf. *Gleitman v. Cosgrove*, 49 N.J. 22, 30, 227 A.2d 689, 693 (1967) (court presumed that a child would choose "life with defects as against no life at all").

119. Some argue that there is no moral difference between active and passive euthanasia. Rachels, *Active & Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975). Although this may be true, maintaining a legal distinction is one way to minimize the possibility of abuse. Moreover, this legal distinction is not an artificial one. The traditional common-law right to bodily integrity permits patients to prevent others from administering unwanted medical treatment, see notes 68-69 *supra* and accompanying text, but there is no common-law right to kill oneself or to have another do so, see notes 5-8 *supra* and accompanying text.

120. This approach would protect patients like Saikewicz from having their mental retardation used as an excuse for denial of easily administered and easily tolerated treatment for curable conditions, such as antibiotics for treatment of pneumonia. Only treatment that itself causes a significant change for the worse may be the subject of a substituted judgment decision. See Brant, *supra* note 46, at 969.

This standard, however, may be more easily stated than applied. For example, Schultz, Swartz & Appelbaum, *supra* note 41, at 945, cite studies indicating that profoundly retarded persons have

The effect of death on population and productivity may afford the state an economic interest in opposing the death of any person,¹²¹ but this interest is clearly inapplicable to seriously or terminally ill patients who have no productive capacity to offer the state.¹²² Moreover, even if the patient could contribute to the economy, the state can claim no compelling interest in productivity. Healthy people are not forced to work,¹²³ and working people need not maximize their productivity.¹²⁴

little sensitivity to pain. If that is true, it would be hard to judge whether therapy that would cause harm in the form of pain to a non-retarded person would also cause harm to a retarded one.

121. Suicide is an offense "against the king, who hath an interest in the preservation of all his subjects." 4 W. BLACKSTONE, COMMENTARIES *189. Some commentators view this statement as referring to the state's interest in population and productivity. G. WILLIAMS, *supra* note 5, at 275-76. See also Cantor, *supra* note 15, at 242-43; Paris, *supra* note 15, at 24; Note, *supra* note 110, at 1660. Courts in several cases have relied on the state's economic interest in human life. See *State v. Lee*, 51 Hawaii 516, 465 P.2d 573, 576 (1970) (motorcycle helmet laws prevent the threat to "the very fabric of society" posed by the increasing number of deaths and injuries to motorcyclists); *People v. Carmichael*, 56 Misc. 2d 388, 390, 288 N.Y.S.2d 931, 935 (Genesee County Ct. 1968) ("It is in the interest of the state to have strong, robust, healthy citizens, capable of self-support, of bearing arms and of adding to the resources of the country"); *Swann v. Pack*, 527 S.W.2d 99, 113 (Tenn.) (state interest in a "strong, healthy, robust, taxpaying citizenry capable of self-support and of bearing arms and adding to the resources and reserves of manpower" justifies prohibition of religious snake-handling practices), *cert. denied*, 424 U.S. 954 (1976). The idea that an individual must live to contribute to the welfare of the state, however, contradicts many of our traditional values. See notes 138, 143, 149 *infra* and accompanying text.

One commentator points out the logical consequences of arguing that the state's economic interest overrides the patient's liberty interest. Because most things people do have some effect on the state treasury, limits on the police power would disappear. He suggests a state might argue that the welfare of the economy requires that everyone go to bed at 10 p.m. Note, *supra* note 7, at 365.

122. In these cases the state's economic interest *opposes* lifesaving treatment. The cost of the treatment itself is often very high. *Hearings, Death with Dignity*, *supra* note 111, at 66-67 (statement of Warren T. Reich). Moreover, treating these patients may deprive others, who might otherwise recover and continue contributing to the gross national product, of necessary medical resources. *Id.* at 30 (statement of Dr. Walter W. Sackett, lamenting that "1,500 severely retarded, who never had a rational thought," are being maintained at great cost to the state, while 125 kidney patients, "whose lives could be prolonged in a useful state," face death because the state could not afford to assist dialysis programs); *Hearings, Medical Ethics*, *supra* note 42, at 5 (statement of Dr. Raymond S. Duff); *Hearings, Moral Questions*, *supra* note 111, at 15 (statement of David Plate, describing one patient's family "eyeing" the family of a hopelessly unconscious patient who used the hospital's only respirator for over 50 days and nights).

123. *Ex Parte Hudgins*, 86 W. Va. 526, 103 S.E. 327 (1920), held a compulsory work law unconstitutional. *State v. McClure*, 30 Del. 265, 105 A.712 (1919), upheld a similar statute only as a war measure. Vagrancy statutes punishing those without regular employment or visible means of support, when not declared unconstitutional, are upheld on grounds unrelated to productivity. See Annot., 25 A.L.R.3d 792, 805-11 (1969).

124. "[S]ociety, generally committed to a free market economy, normally refrains from compelling individuals to maximize their productive potential . . ." The author cites Galbraith's analysis of the role of women as "crypto-servants" as an example of encouraging actual waste of productive potential. Note, *supra* note 110, at 1660.

Finally, if such a compelling interest did exist, compulsory medical treatment would be an impermissibly broad means to effectuate it.¹²⁵

Protecting the individual from the irrevocable consequences of a hasty and ill-considered act is the state's most compelling interest in preventing suicide¹²⁶ and is equally significant in cases in which patients refuse life-saving medical treatment. Surprisingly, states have not asserted this interest in any of the recent medical treatment cases. States should assert an interest in protecting patients from the dangers of mistaken diagnoses and overly pessimistic prognoses:¹²⁷ a "hopeless" illness,¹²⁸ an "irreversible" coma,¹²⁹ or a "dead" brain¹³⁰ may not

125. When a fundamental right is threatened, even a compelling state interest must be effectuated only by the narrowest possible means. *Roe v. Wade*, 410 U.S. 113, 155 (1973).

126. *See Superintendent of Belchertown v. Saikewicz*, — Mass. —, — n.11, 370 N.E.2d 417, 426 n.11 (1977).

Many attempted suicides are believed to be appeals for help rather than genuine attempts to kill oneself. *E.g.*, N. ST. JOHN-STEVAS, *supra* note 5, at 256; Cantor, *supra* note 15, at 256. The state and individual interests in life are thus congruent, and the state is merely effectuating its traditional interest in protecting those who want to live. Here the person needs protection from himself or herself, rather than from another.

The state's interest in protecting individuals from the undesired fatal consequences of their own ill-considered acts may also explain policies towards risk-takers such as snake-handlers and helmetless motorcyclists. *See* notes 6-8 *supra* and accompanying text. These people do not want to die and do not think they are going to, but the state has weighed the risks differently and imposes its own restrictions. *Cf.* L. TRIBE, *supra* note 74, at 940 (the most convincing rationale for motorcycle helmet requirements is the protection of motorcyclists from peer pressure).

127. Kamisar, citing several cases and studies, argues that mistaken diagnosis of a terminal illness is a real possibility, and a reason to oppose voluntary euthanasia. Kamisar, *supra* note 117, at 993-1006.

128. *E.g.*, *Hearings, Death with Dignity*, *supra* note 111, at 23 (statement of Dr. Laurance V. Foye); *Hearings, Medical Ethics*, *supra* note 42, at 8 (statement of Dr. Raymond S. Duff); *cf. id.* at 15, 45 (statement of Dr. Robert E. Cooke about whether accurate predictions about quality of life are possible).

129. *Hearings, Moral Questions*, *supra* note 111, at 42-44 (letter from Robert W. Hicks).

The *Quinlan* court seems either to have been inadequately sensitive to this problem or to have evaded it. In the early parts of the opinion, the court admitted that there is a remote possibility that Quinlan might recover, 70 N.J. at 26, 355 A.2d at 655, and used language like "no reasonable hope," and "probably irreversibly doomed," *id.* at 33, 38, 355 A.2d at 659, 662 (emphasis supplied); however, the court, in rendering its decision, categorically stated "she will never resume cognitive life," *id.* at 41, 355 A.2d at 664 (emphasis supplied). Though the ethics committee must verify the attending physician's judgment that there is no reasonable hope of a return to cognitive sapient life, *id.* at 54, 355 A.2d at 671, there is no discussion or consideration of how much hope is necessary for it to be "reasonable," or of the standard of proof to be met.

130. *E.g.*, van Till, *Diagnosis of Death in Comatose Patients under Resuscitation Treatment: A Critical View of the Harvard Report*, 2 AM. J. OF LAW & MED. 1 (1976). There are occasional newspaper reports of persons declared brain-dead who were found to be alive during preparation for organ donation.

The concept of brain death has gained popularity due to medical advances allowing the artifi-

be that at all. In addition, the states should insist that courts attempt to ascertain whether the patient truly understands the nature of his or her illness and the effects of refusing treatment, and whether refusal is truly the patient's wish.¹³¹ Finally, if the patient is incompetent, the state should insist on procedural safeguards¹³² and careful judicial scrutiny of a "substituted judgment" decision to withhold treatment.¹³³ By taking these steps, the state will effectuate its traditional interest in preserving the lives of those who want to live.

cial maintenance of respiration and circulation after destruction of the nervous system. Many believe that death should, therefore, be determined not by cessation of respiration and circulation, but by termination of brain function. "Brain death" requires the permanent cessation of both "higher" and "lower" brain functions. See, e.g., Biörck, *supra* note 2, at 492-94; Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 89, 112 n.89 (1972).

Numerous standards have been developed to ascertain the death of the brain. E.g., Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J.A.M.A. 337 (1968); Hirsch & Donovan, *supra* note 42, at 291-95; Hoffman & Van Cura, *Death—The Five BRAIN Criteria*, 1978 MED. TRIAL TECH. Q. 377.

There is growing judicial acceptance of brain death. See, e.g., *Lovato v. District Court*, — Colo. —, 601 P.2d 1072 (1979); *In re Cain*, 44 Fla. Supp. 208 (Cir. Ct. 1976) (allowed brain dead patient to be removed from respirator); *Commonwealth v. Golston*, — Mass. —, 366 N.E.2d 744 (1977) (adopted brain death for limited purposes of homicide prosecutions, and cited other cases that did the same); *New York City Health & Hosps. Corp. v. Sulsona*, 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (1975) (adopted brain death for purposes of the state's Anatomical Gift Act to facilitate organ transplants).

Twenty-three states have adopted brain death statutes. A Uniform Brain Death Act was approved in 1978. 12 UNIF. L. ANN. 10 (West Supp. 1979).

131. Kamisar fears for patients "who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act." Kamisar, *supra* note 117, at 990.

A recent article warns against "superficial and automatic acquiescence to the concepts of patient autonomy and death with dignity," and cites examples of patients whose original requests that treatment be withheld were found not to express their true desires. (E.g., one patient changed his mind several times; a second was depressed because of illness and could not believe treatment would help; a third was attempting to escape other potentially solvable problems in his life; a fourth was frightened by the hospital equipment but eventually accepted reassurance and agreed to treatment). Jackson & Younger, *Patient Autonomy & "Death with Dignity: Some Clinical Caveats*, 301 NEW ENG. J. MED. 404, 405-08 (1979).

Some courts have shown concern for ascertaining a patient's true wishes. For example, in blood transfusion cases courts often ask if the patient would object to court-ordered treatment, see cases cited in note 15 *supra*; courts dealing with elderly patients carefully scrutinize the patient's competency and ability to understand what is happening before allowing refusal of treatment, see notes 37, 39 *supra* and accompanying text.

132. *Saikewicz's* requirement of a guardian *ad litem*, who must argue for treatment before the court can substitute its judgment for the incompetent patient's, is a valuable procedural safeguard.

133. For examples, see notes 119-20 *supra* and accompanying text.

V. FACTORS IN THE BALANCING PROCESS

An analysis of the recent cases indicates some factors courts deem relevant in balancing the individual's right to refuse treatment against the state's interest in life. These factors include the type and effects of the proposed treatment, the "quality of life" the patient will have if treated, the length of time the patient will live, and the patient's usefulness to society.

A. *Type and Effects of Proposed Treatment*

Courts usually permit patients to refuse medical treatment that will cause pain and suffering, particularly if the treatment offers only a brief prolongation of life.¹³⁴ The greater the patient's suffering, the stronger the patient's interest in refusing treatment.¹³⁵ The degree of "intrusiveness" of the proposed procedure is also deemed significant and affects the patient's right to refuse.¹³⁶ The emphasis on bodily intrusion, however, is misplaced. The "right to privacy" relies not on the degree of intrusion into one's body space, but rather on the right to decide one's own fate.¹³⁷ Moreover, it is impossible to quantify or differentiate "degrees" of intrusion. Any type of treatment capable of transforming a dying patient into a living one so significantly alters the patient's bodily functioning that it must be deemed "intrusive." The only proper relevance of degree of bodily "intrusion" is the degree of pain or discomfort caused the patient.

B. *The "Quality of Life"*

Despite broad statements that "quality of life" concerns are irrelevant to judicial decision-making,¹³⁸ courts have considered aspects of

134. See *Superintendent of Belchertown v. Saikewicz*, — Mass. —, 370 N.E.2d 417 (1977); cases cited at note 27 *supra*.

135. See — Mass. at —, 370 N.E.2d at 425-26.

136. *E.g.*, *Lane v. Candura*, — Mass. App. Ct. —, — n.2, 376 N.E.2d 1232, 1233 n.2 (1978); *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976); *In re Quackenbush*, 156 N.J. Super. 282, 289-90 & n.2, 383 A.2d 785, 789 & n.2 (1978).

137. See *Roe v. Wade*, 410 U.S. 113, 154 (1973).

138. *E.g.*, *Maine Medical Center v. Houle*, No. 74-145 (Cumberland County Super. Ct., Me., Feb. 14, 1974), excerpted in WEIR, *ETHICAL ISSUES IN DEATH AND DYING* 185, 186 (1977) ("the issue before the court is not the prospective quality of the life to be preserved, but the medical feasibility of the proposed treatment"); *Superintendent of Belchertown v. Saikewicz*, — Mass. —, —, 370 N.E.2d 417, 432 (1977) (it is improper to equate the "value of life with any measure of the quality of life"); *Berman v. Allen*, 80 N.J. 405, —, 404 A.2d 8, 12 (1978) (finding mongoloid child who had been born because doctor negligently failed to inform parents of possibilities of discover-

the quality of the life the patient would have if treatment were successfully administered. Some of the recent cases have indicated that the state has little interest in preserving non-cognitive life.¹³⁹ These cases do not explain why cognitive ability is significant, nor why it affects the state's interest rather than the patient's. Most importantly, they fail to clarify the meaning of "cognitive life." The court may require more than mere consciousness; rather, the state's interest in life may also depend on the patient's ability to think and reason.¹⁴⁰ Application of this approach may result in finding that the state has little or no interest in preserving the lives of severely retarded persons who "live a vegetative existence . . . incapable of . . . the most minimal response to stimuli."¹⁴¹

Only the *Quackenbush* court considered the effect of post-treatment disabilities on the fully conscious patient. Although the court did not say so explicitly, the nature of the life Quackenbush would be forced to lead after his life-saving amputation was apparently one factor in the court's allowing him to refuse surgery.¹⁴²

ing defect and aborting, had suffered no cognizable injury and reasoning that "life—whether experienced with or without a major physical handicap—is more precious than non-life"). See also Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 DUKE L.J. 1401, 1445.

Doctors do consider "quality of life" factors in making treatment decisions, at least in cases in which the patient was "normal" before the illness. D. CRANE, *supra* note 3, at 11, 35 (suggesting that the most significant factor in many doctor's decision may be patient's ability to resume social rules).

139. *In re Dinnerstein*, — Mass. App. Ct. —, —, 380 N.E.2d 134, 138-39 (1978); *In re Quinlan*, 70 N.J. 10, 40-41, 355 A.2d 647, 664 (1976); *In re Quackenbush*, 156 N.J. Super. 282, 288-89, 383 A.2d 785, 789 (1978) (dicta); see *Dockery v. Dockery*, 559 S.W.2d 952, 955 (Tenn. Ct. App. 1977).

The growing acceptance of the concept of "brain death," see note 130 *supra*, supports the view that the interest in life depends on the presence of consciousness. See Biörck, *supra* note 2, at 494 (stating that permanent loss of consciousness (or soul) was always the criterion of death, but that consciousness was once thought to depend on the heart). Although consciousness, as far as we know, depends only on "higher" brain functions, brain death requires the destruction of the entire brain, apparently for two reasons. First, permanent loss of only higher functions is not easily verifiable, Capron & Kass, *supra* note 130, at 115 n.97. Second, lower brain functions govern breathing and some reflexes, and society would not permit burial of persons with these functions intact. Task Force on Death & Dying of the Institute of Society, Ethics, & the Life Sciences, *Refinements in Criteria for the Determination of Death: An Appraisal*, 221 J.A.M.A. 48, 53 (1972).

140. *Quinlan* speaks of "cognitive, sapient life," not of mere "consciousness." 70 N.J. at 51, 355 A.2d at 669. The patient in *Dinnerstein* was not unconscious. — Mass. App. Ct. at —, 380 N.E.2d at 135.

141. Robertson, *supra* note 42, at 253.

142. 156 N.J. Super. at 290, 383 A.2d at 789 n.2. Although from the state's point of view the maintenance of cognitive, sapient life indicated a good prognosis, the court admitted that due to

C. *Age and the Length of Time a Patient Will Live*

Although the courts show clear solicitude for preserving the lives of the elderly,¹⁴³ there is also evidence that the state's interest in life diminishes when the patient has little time left to live. The *Quackenbush* court, in deciding not to compel amputation, apparently relied, in part, on the patient's age.¹⁴⁴ Similarly, the other courts find only a limited state interest in "prolonging" the lives of terminally ill patients whose lives cannot be "preserved," and who will not live long even if treated.¹⁴⁵

Tying the length of time the patient will live to the state's interest in life implies that a state has little interest in the lives of the elderly—an implication with consequences undoubtedly abhorrent to the judges who wrote these decisions. The courts could avoid this implication by tying the potential for long life after treatment to the patient's interest rather than to the state's. Those patients who claim less interest in life when little time remains would be able to refuse treatment. On the other hand, those who wish to hold on to life as long as possible need not fear a countervailing state interest.

D. *Usefulness and Productivity*

There is some basis for saying that courts view the perceived social and economic "usefulness" of a patient's life as increasing the state's interest.¹⁴⁶ Although none of the medical treatment cases considered a

the resulting disabilities, *Quackenbush* had a negative view of his prognosis. Despite the court's statement that the patient's view of his prognosis would not be considered, it is difficult to see what other special "circumstances" justified departure from *Quinlan's* requirement of a dim prognosis from the state's point of view. This case seems to be based on a combination of autonomy considerations, age, see note 144 *infra* and accompanying text, and quality of life.

143. Courts routinely order surgery for incompetent elderly patients. See note 39 *supra* and accompanying text. *Saikewicz* stated that "[a]ge is irrelevant . . . to the question of the value or quality of life." — Mass. at — n.17, 370 N.E.2d at 432 n.17.

144. The court distinguished *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971), which had relied on the state's interest in life and ordered a blood transfusion for a young woman. The *Quackenbush* court noted that the young woman had a "long life and vibrant health potential," a potential *Quackenbush* did not share. 156 N.J. Super. at 289-90, 383 A.2d at 789. Because *Quackenbush*, after surgery, would have had no life-threatening disease, it could only be his age that stood in the way of a "long life."

145. The *Saikewicz* court found the state has less interest in life in cases in which "life will soon, and inevitably, be extinguished." — Mass. at —, 370 N.E.2d at 425. *Dinnerstein* indicated that neither the state nor the patient has an interest in life when very little time is left. — Mass. App. Ct. at —, 380 N.E.2d at 138-39. See also cases cited at note 27 *supra*.

146. Physicians do not consider the patient's "social worth" in making treatment decisions,

patient's general productive capacity, one leading case based compulsion of treatment on the patient's obligation to support her child, and other courts have approved this reasoning.¹⁴⁷ Cases indicating diminished state interest in lives of persons who are unconscious or have little time left to live further support the view that courts emphasize usefulness and productivity, because they are the only state interests affected by these factors.

It is surprising to find judicial opinions indicating that one's productivity determines the value the state attaches to one's life. Such holdings contradict other judicial language emphasizing the value of all life,¹⁴⁸ run counter to the liberal tradition and respect for the individual long cherished in our society,¹⁴⁹ are in derogation of the Constitution's protection of the lives of all persons, and therefore constitute a dangerous and surprising body of precedent.

VI. CONCLUSION

Three legal bases may justify allowing a competent patient to refuse life-saving medical treatment: the right to free exercise of religion,¹⁵⁰ the constitutional right of privacy,¹⁵¹ and the common-law right to bodily integrity.¹⁵² Permitting a proxy to exercise an incompetent patient's right of privacy, and refuse treatment even though the patient had never made a choice while competent, is inappropriate, for the right to privacy is a right to make decisions for oneself.¹⁵³ Courts may, however, appropriately authorize withholding treatment from an incompetent patient on the basis of common-law respect for the dignity of the human body, if this is the decision the patient would have made if com-

according to D. CRANE, *supra* note 3, at 61. Social worth is relevant in other decisions of great significance to the individual, e.g., sentencing, and at least one hospital's selection of patients for hemodialysis. Sanders & Dukeminier, *supra* note 52, at 371, 375-78.

147. See note 14 *supra* and accompanying text.

Several of the motorcycle-helmet and snake-handling cases found a general state interest in population and productivity. See note 121 *supra*.

148. See notes 138, 143 *supra*.

149. "The 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." *In re Osborne*, 294 A.2d 372, 375 n.5 (D.C. Ct. App. 1972).

150. See notes 53-57 *supra* and accompanying text.

151. See notes 58-71 *supra* and accompanying text.

152. See notes 68-69, 77-79 *supra* and accompanying text.

153. See notes 73-76 *supra* and accompanying text.

petent.¹⁵⁴

No state interest is compelling enough to override a competent patient's refusal of life-saving medical treatment.¹⁵⁵ There is no need for courts to undertake a case-by-case balancing of interests in cases in which the patient is competent. The state, however, should effectuate its traditional interest in preserving life by attempting to guard against the dangers of mistaken diagnoses and ill-considered decisions.¹⁵⁶

The state may play a larger role in cases involving incompetent patients.¹⁵⁷ The courts should continue to follow the "substituted judgment" approach, with its focus on the needs and desires of the individual patient, and permit decisions against treatment only in limited circumstances¹⁵⁸ and only after application of strict procedural safeguards.¹⁵⁹ If the state asserts an interest in the promotion of a pro-life morality against a proxy's decision to reject treatment, the court should carefully scrutinize the asserted interest and weigh it against the strength of the patient's interest in avoiding treatment.¹⁶⁰

Many of the decisions evince a concern that patients not suffer,¹⁶¹ and an insistence that the right to life not be compromised by a patient's age or disabilities.¹⁶² On the other hand, courts are less likely to compel treatment of patients who are unlikely to regain cognitive life,¹⁶³ have little time left to live,¹⁶⁴ or are not socially useful.¹⁶⁵ The judicial handling of these issues suggests that a utilitarian view of the value of human life is developing—a view with dangerous implications. More careful judicial analysis of the state's interest and the factors involved in treatment decisions is required to obviate these dangers.

The state has a proper role as protector of life in medical treatment cases. That role is not to insist on preserving life until the last possible moment at great human cost and with no benefit to the patient. Rather, it is to ensure the clarification of facts and the purification of the deci-

154. See notes 72-80 *supra* and accompanying text.

155. See notes 83-120 *supra* and accompanying text.

156. See notes 127-31 *supra* and accompanying text.

157. See text following note 79 *supra*.

158. See notes 119-20 *supra* and accompanying text.

159. See note 132 *supra* and accompanying text.

160. See note 115 *supra* and accompanying text.

161. See note 134 *supra* and accompanying text.

162. See notes 138, 143 *supra* and accompanying text.

163. See notes 139-41 *supra* and accompanying text.

164. See notes 144-45 *supra* and accompanying text.

165. See notes 146-47 *supra* and accompanying text.

sion-making process. The challenge facing the courts is to decide the cases in a way that leaves no doubt that the state's interest in protecting lives extends to all citizens, but with the aim of enhancing, not diminishing, human dignity and autonomy.

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