Euthanasia and the Terminally Ill Patient

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I. INTRODUCTION

"Death with dignity" is a slogan that matches the best Madison Avenue has ever produced. Today the legal profession is buying this "new and improved" product without any careful consideration of the justification for its existence. Euthanasia, or mercy kill-
ing, a concept that has been debated by mankind for centuries. With the abuses of the Nazi reign during World War II, however, all serious consideration of euthanasia was temporarily halted.

The modern post-war debate began in 1957 with Professor Glanville Williams' comments on euthanasia in his book, The Sanctity of Life and the Criminal Law. Professor Kamisar responded one year later with an article critical of the pro-euthanasia cause. Since the Kamisar article, a great deal of emotional rhetoric has been traded over the issue, but no serious attempt has been made to evaluate the anti-euthanasia arguments in light of the modern trend described by the slogan "death with dignity.

This Article will examine both the arguments against euthanasia and the experience of a world that is rapidly beginning to accept euthanasia, in an effort to assess the wisdom of the current pro-euthanasia trend. The argument will be made that the anti-euthanasia cause, despite the impact of certain recent technological and sociological changes, is largely alive and well worth resuscitating.

II. THE PRO-EUTHANASIA TREND

This Article will focus its examination of the pro-euthanasia trend on three major manifestations of that trend—the Quinlan case, the Saikewicz case, and so-called Living Will statutes that have been enacted by several states. Although the trend does not exist in such a simple form, focusing on these three concrete and widely discussed manifestations will reveal significant weaknesses

1. In an effort to meet the proponents of euthanasia, this Article will employ the sales techniques they use so successfully. As if an analytical difference were involved, I will gradually re-introduce the less antiseptic term "mercy-killing" for the now popular term, "euthanasia." "Obligation to terminate" will replace "right to refuse invasive treatment," and the term "preservation of life" will be used to embrace the "anti-euthanasia" view.
2. See Kamisar, infra note 3, at 969 n.2.
3. Kamisar, Some Non-Religious Views Against Proposed Mercy-Killing Legislation, 42 Minn. L. Rev. 969 (1958). Professor Kamisar used this somewhat unusual title because Williams had suggested that the only arguments against euthanasia were based on the religious beliefs of certain groups. See G. Williams, The Sanctity of Life and the Criminal Law 312 (1957).
5. See infra notes 107-108 and accompanying text.
6. See infra notes 109-111 and accompanying text.
9. See infra note 43.
in the trend's position that cannot be negated by the inclusion of additional details and variations.

A. The Quinlan Case

_In re Quinlan_ [10] was the first significant formal [11] adjudication in this country of the issue of whether euthanasia should be allowed in the case of a terminally ill patient. With the eyes of the nation upon them, the Supreme Court of New Jersey improperly ignored prior New Jersey law and produced a decision plagued with major logical faults and factual inaccuracies. The disastrous opinion in _Quinlan_, however, was not simply the product of poor judicial craftsmanship; the decision was inherently difficult due to the values enshrined in the concept of mercy-killing.

Before analyzing the holding in _Quinlan_, agreement on the facts of the case must be reached. Ordinarily, the facts of a case can be ascertained from the opinions of the courts that have considered them. However, the contrast between the trial court's opinion [12] and that of the New Jersey Supreme Court [13] is so great that it is difficult to believe that two courts were discussing the

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10. 70 N.J. 10, 355 A.2d 647, _cert. denied sub nom_. Garger v. New Jersey, 429 U.S. 922 (1976). Certiorari was not sought by any of the parties in the case, but a right-to-life group sought to intervene and brought the case to the U.S. Supreme Court, obviously lacking standing to do so.

11. There is a great deal of evidence that physicians have been informally making _Quinlan_-type decisions. See, e.g., _In re Quinlan_ 70 N.J. 10, 46-47, 54, 355 A.2d 647, 667, 671 (1976).


Karen's condition was described as rather debatable:

- Hospital records at the time of admission reflected [sic] Karen's vital signs to be normal. . . . He [Dr. Morse] found her in a state of coma, with evidence of decortication indicating [an] altered level of consciousness. . . .
- He found her oculo cephalic and oculo vestibular reflexes normal. [Description of the tests omitted.]
- He also found pupillary reaction to light in both eyes.

. . .

Dr. Jared testified [that] the blood tests were all normal while Karen was on the respirator. . . .

Dr. Morse indicated that the EEG performed at the outset established nothing abnormal for a comatose person, and did not establish the offending agent to her central nervous system which caused her unconsciousness. Subsequent EEG's provided no further information. All indicated brain rhythm or activity.

Id. at 237-240, 348 A.2d at 806-08.

Karen was characterized by her physicians as “viable,” and suprisingly active:

. . .

2. There was always a reaction to painful stimuli, she responded
same case. Although the trial court heard the evidence and, therefore, would be presumed to be the more reliable finder of
de cerebrately to pain, she sometimes would grimace as if in pain, which would be followed by increased rigidity of her arms and legs;
3. There would be periodic contractions and spasms, periodic yawning . . . ;
4. Pupils were sometimes dilated, sometimes normal, but almost always sluggish to light;
9. Sometimes she would trigger spontaneous breathing without the aid of and assist the respirator; sometimes she would go for periods without triggering it at all.

Id. at 241, 348 A.2d at 808-09. Most shockingly, the court found that “[o]n May 7 nurses indicated she blinked her eyes two times when asked to and appeared responsive by moving her eyes when talked to, but there is no further evidence of this type of reaction thereafter.” Id. at 241, 348 A.2d at 809 (emphasis added). Karen’s condition was described by Dr. Morse as a “sleep-awake type comatose condition.” Id. More importantly, the court noted that Dr. Morse was “unwilling to say she is in an irreversible state or condition.” Id. at 245, 348 A.2d at 811 (emphasis added). Notwithstanding this uncontradicted statement, the supreme court found her condition to be irreversible. See infra note 13.

In addition, the trial court opinion included the following details: Karen cried, during which time her mouth opened; her EEG showed normal activity for a sedated person (she was sedated for the EEG); she breathed spontaneously at times; she did not have locked-in syndrome. Id. at 246, 348 A.2d 811. It should be noted that the trial court stated, although inconsistent with the evidence and its own findings, that “All agree she is in a persistent vegetative state.” Id. In view of the fact that Dr. Morse’s statement to the contrary appears earlier on the same page, this finding is difficult to explain. The trial court repeated this conclusion, and then said “there is some medical qualification on the issue of her returning to discriminative functioning . . . .” Id. at 257, 348 A.2d at 817.

The trial court concluded that the right to terminate Karen’s life would not exist in a case where there was some doubt about her prognosis. The decision in this case to discontinue life support was left to her physicians, who had testified that they did not feel her case warranted termination. Id. at 259, 348 A.2d at 818.

13. There was no opinion by the appellate court. See In re Quinlan, 70 N.J. 10, 18, 355 A.2d 647, 651 (1976). In contrast to the trial court, see supra note 12, the supreme court “found” Karen’s EEG to be “abnormal, but it showed some activity.” In re Quinlan, 70 N.J. 10, 23, 355 A.2d 647, 655-56 (1976). The court also found that death would soon follow from her removal from the respirator. Id. at 25, 355 A.2d at 655-56. See also infra note 102 and accompanying text.

More importantly, the court asserted that, “she can never be restored to cognitive or sapient life.” Id. at 26, 355 A.2d at 658 (emphasis in original).

14. It should also be noted that the trial court found, supported by the testimony of all but one rather incredible witness, that the use of a respirator was “ordinary” rather than “extraordinary” treatment. In re Quinlan, 137 N.J. Super. 227, 247-48, 348 A.2d 801, 812 (1975). The supreme court, however, accepted the church’s characterization of these efforts as extraordinary. In re Quinlan, 70 N.J. 10, 31, 355 A.2d 647, 658 (1976).
fact, it is also necessary to review the questionable independent factual conclusions drawn by the supreme court since Quinlan turns on the New Jersey Supreme Court's findings of fact.

From the outset, it must be assumed that Karen Ann Quinlan, an otherwise healthy young woman, was in a comatose condition with no hope of return to sapient human life. The question before the court was whether Karen's parents, acting as her guardians, had the legal power to disconnect her respirator and trigger her inevitable death. Only five years before Quinlan, a unanimous New Jersey Supreme Court, in John F. Kennedy Memorial Hospital v. Heston, held that "there is no constitutional right to choose to die." In Heston, a twenty-two-year-old unmarried woman who had been severely injured in an auto accident refused a life-saving blood transfusion for religious reasons. Heston presented the difficult case of an adult with no dependants, who simply wished to avoid intrusive medical intervention as a matter of free choice. In an insightful opinion, the court held that the state's inherent interest in the preservation of human life was par-

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15. See, e.g., F. JAMES & G. HAZARD, CIVIL PROCEDURE 677 (2d ed. 1977), in which it is stated that "[a]ppellate review is not a retrial of the case, but rather a review concerning whether prejudicial error occurred in its original determination" and that "review of factual determination is very limited." Id. at 678 (emphasis in original). See also id. at 678-80.


17. See supra note 12 & infra note 102 and accompanying text.


It must be noted that the first amendment right of freedom of religion is, on a comparative constitutional scale, far more important to the functioning of our democratic society than "medical privacy." Under this analysis, the patient in Heston should have been allowed to decline blood transfusions and Karen Quinlan should not have been allowed to do so. Unfortunately, the New Jersey Supreme Court reaches the opposite result.

20. Cf. Application of the Pres. and Directors of Georgetown College, Inc., 331 F.2d 1000, 1010 (D.C. Cir.), cert. denied, 377 U.S. 975 (1964). In this case, Judge J. Skelly Wright made a similar decision merely on the basis that it was necessary to preserve the status quo—thereby deciding the lawsuit. Id. at 1007. Judge Miller, in his opinion dissenting from denial of an en banc rehearing stated: "the orders entered on September 17 by one judge of this court did not preserve the status quo ante by granting fully and finally all of the relief sought, thus disposing of the matter on its merits." Id. at 1014.

It is clear that Judge Wright believed that the patient, in light of her lack of serious opposition, wanted him to order the transfusion despite her token
amount, and ordered the transfusion.\(^{21}\)

In light of *Heston*, the first embarrassingly weak link in the *Quinlan* chain of analysis was exposed when the *Quinlan* court concluded that an individual has a "privacy" right to choose freely to terminate her own life.\(^{22}\) This proposition is without any accurate citation of authority,\(^{23}\) and, of course, the court omits any accurate reference to the *Heston* decision. The court does cite to the concept of a federal right of privacy, but follows this discussion with the statement, "nor is such right of privacy forgotten in the

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21. The court found:

The solution sides with life, the conservation of which is, we think, a matter of state interest. A prior application to a court is appropriate if time permits it, although in the nature of the emergency the only question that can be explored satisfactorily is whether death will probably ensue if medical procedures are not followed. If a court finds, as the trial court did, that death will likely follow unless a transfusion is administered, the hospital and the physician should be permitted to follow that medical procedure.


*Heston* is discussed in the *Quinlan* opinion solely for the odd and largely unnecessary proposition that freedom of religion is not an absolute right. While *Heston*, in a broad sense, does stand for this proposition, Karen Quinlan's religion did not prohibit the proposed mercy-killing; in fact, her church filed an *amicus* brief in favor of it. *In re Quinlan*, 70 N.J. 10, 35, 355 A.2d 647, 661 (1976). Thus, any freedom of religion objection to her termination was largely irrelevant.

On the other hand, the parties saw *Heston* as the crucial case to either follow, overrule, or distinguish. This is especially true from the perspective of the hospital and doctors, who, statements in the supreme court's opinion notwithstanding, opposed Karen Quinlan's termination. For example, the trial court noted: "All defendants rely on *John F. Kennedy Memorial Hospital v. Heston* . . . to challenge the constitutional claims, asserting that no constitutional right to die exists and arguing a compelling state interest in favor of preserving human life." *In re Quinlan*, 137 N.J. Super. 227, 251, 348 A.2d 801, 814 (1975) (citation omitted). It simply strains credulity to suggest that the New Jersey Supreme Court, which was obviously aware of *Heston*, did not see its direct relevance to the case.
New Jersey Constitution.” Therefore, it is obvious that, in view of Heston, the right to privacy in Quinlan is a major leap from existing authority. In a common law jurisdiction, however, the courts often make new law and discard the old, albeit usually with a somewhat greater degree of candor and some probing analysis of the policy reasons for doing so.

Even assuming, arguendo, that this right of privacy somehow exists in the law of New Jersey or the federal constitution, the second weak link in the Quinlan analytical chain is exposed. If there is a right to privacy, it is a right that the individual (Karen Quinlan) possesses as against the government and all others. While the concept is well-established in the area of probate law that an incompetent person’s rights ought to be protected by allowing someone else to exercise those rights on behalf of the incompetent person, it is not clear that such a concept ought to be extended by facile analogy to the unique right of privacy as pronounced by the Quinlan court. In essence this right exists because there are choices that belong to the individual alone. Unless the individual is capable of exercising those choices, they do not exist; just as a father is not allowed to decide whether his twenty-two-year-old daughter may have an abortion. To say the individual’s right to choose continues to exist because we give these private choices to someone else is to engage in Orwellian newspeak.

Again assuming, arguendo, that the individual not only has this

25. First amendment rights, which succumbed to the state’s interest in preserving life in Heston, see supra notes 18-21 and accompanying text, seem superior to the judicially created right of privacy. A candid appraisal of the issues by the New Jersey court would require that Heston be overruled. Obviously, this was not the court’s intent. However, the court apparently had no rational way of harmonizing or distinguishing the two decisions.
26. For example, Warren and Brandeis, who are generally credited with originating modern thought on privacy, defined it as the “right to be let alone.” See Warren & Brandeis, The Right to Privacy, 4 HARV. L. REV. 193, 193 (1890). The phrase was actually coined by Judge Cooley. Id. at 195 n.4. “In every . . . case the individual is entitled to decide whether that which is his shall be given to the public.” Id. at 199 (emphasis added). See also Planned Parenthood v. Danforth, 428 U.S. 52 (1976); infra note 30.
27. See, e.g., In re du Pont, 41 Del. Ch. 300, 194 A.2d 309 (1963). The trustee for an incompetent acts as a substitute for the incompetent, and, subject to the control of the court, does whatever is necessary for the care and preservation of the incompetent’s estate: “The court has, for the benefit of the [incompetent] ward . . . all the powers over his estate which he could exercise, if present and not under a disability, except the power to make a will.” N.J. STAT. ANN. § 3B: 12-49 (West 1883). The remainder of the section, however, demonstrates by the examples it employs that this power is designed to deal with financial matters and the like. See also Hyland & Baime, In Re Quinlan: A Synthesis of Law and Medical Technology, 18 JURIMETRICS J. 107 (1977).
newly found, well-established right to privacy, but that this right of privacy can be protected by the questionable means of giving the right to another who decides for the individual, the third weak link in the Quinlan chain still must be faced. Having given the individual the right to privacy, the Quinlan court concludes that the decisions as to the exercise of this right of privacy should be made by the patient, the patient's family, the patient's physician, and the now-famous hospital "ethics" committee. Considering the number of persons and entities with an apparent veto power, the result is that a privacy decision is made by popular election. The procedure is obviously ill-conceived; indeed, in Karen Quinlan's case, once the hospital ethics committee was formed, it, in ef-

28. Certainly the tone of the Quinlan opinion suggests that the privacy right was not even debatable, but rather had clearly existed all along. A lie stated confidently, perhaps will be believed.


The Quinlan court, not perceiving the conflict between such a notion and privacy, found the "diffusion of . . . responsibility for decision" to be a desirable aspect of such a process. In re Quinlan, 70 N.J. 10, 50, 355 A.2d 647, 669 (1976). If the analogy to Griswold is appropriate (and the Quinlan court thought that it was), the result is similar to deciding whether an individual should use contraceptives by putting the issue to a popular vote. This, of course, is what Griswold held that the state of Connecticut could not do. Griswold v. Connecticut, 381 U.S. 479 (1965).

Further, the Quinlan opinion failed to mention the composition of such ethics committees, since the court seemed to assume that hospitals already had them. The Attorney General of the State of New Jersey and the Assistant Attorney General, who appeared for the state in Quinlan, have discussed their experience with the case. See Hyland & Baime, In Re Quinlan: A Synthesis of Law and Medical Technology, 18 JURMЕТМЕТС J. 107 (1977). They noted that not a single hospital in the state had an ethics committee at the time. The Attorney General's office was soon besieged with requests to define the appropriate membership of such a committee. The Attorney General's reply, in the general thoughtless spirit of the Quinlan opinion, included members of the clergy as participants on the committee. Members of the clergy now appear on ethics committees as mandated by New Jersey law.

Further, Hyland and Baime admit that the court did not define the range of the "family" to be included, noting that, "[a]lthough this appears to be a simple matter, difficult questions might well arise when members of a family disagree . . . ." Id. at 126. See also infra note 94 and accompanying text.

30. Even Hyland and Baime, see supra note 27, at 124 & 127, expressed a concern that such an arrangement itself might be an unconstitutional invasion of privacy. Planned Parenthood v. Danforth, 428 U.S. 52 (1976), may be read as both rejecting any substituted right of privacy and rejecting such a system of veto rights, holding that the putative father of a fetus possesses no privacy right to veto the mother's abortion request, either on his own behalf (as the family had in the Quinlan decision mechanism), or on behalf of the fetus (as Karen's father had, according to Quinlan).
fect, nullified the supreme court's holding by deciding not to allow Karen's termination. In a forum shopping effort unmatched since the days of Harris v. Balk, the Quinlans moved Karen to another hospital with a more agreeable ethics committee. Even so, Karen did not accommodate anybody, since some seven years after being taken off the respirator, she has not yet died.

B. The Saikewicz Case

The Saikewicz opinion was a significantly better example of legal reasoning. Whatever its faults and contradictions, the Saikewicz court faced a more difficult problem than the Quinlan court had and made a more sincere effort to address it. The most significant problem with the Saikewicz opinion is its implicit and explicit reliance on the unsound Quinlan decision.

Saikewicz was a sixty-seven-year-old man who had developed leukemia. He was in the custody of a state home for the mentally retarded because he was incapable of understanding his own predicament. In addition to trying to avoid the so-called "quality of life" issue (because that issue still bore the tarnish of the World

31. When the ethics committee at the original hospital reached the conclusion that Karen's life ought not be terminated, she was transferred to Morrisview Nursing Home, which then formed an ethics committee. The Morrisview ethics committee agreed to the termination after a final effort to wean Karen from the respirator failed. This information was obtained from telephone interviews with counsel for various parties to the Quinlan case.

32. 198 U.S. 215 (1905).

33. See supra note 31. The suggestion has since been made that Karen's family might now try cutting off the intravenous feeding, if such feeding can be characterized as a "life-sustaining apparatus" within the meaning of the Quinlan opinion. See Hyland & Baime, supra note 29, at 126 n.140. It should now be apparent that the "heroic measures" or "extraordinary care" or "life-sustaining apparatus" distinctions are meaningless. See infra notes 56-61 and accompanying text.


38. The court stated:

Evidence that most people choose to accept the rigors of chemotherapy has no direct bearing on the likely choice that Joseph Saikewicz would have made. Unlike most people, Saikewicz has no capacity to understand his present situation or his prognosis. The guardian ad litem gave expression to this important distinction in coming to grips
War II experience), the Saikewicz court had to deal with a situation that was uniquely difficult because of Saikewicz’s retarded condition. Saikewicz was so severely retarded that he would not have understood the consequences of the horribly uncomfortable process of chemotherapy. He would have had to have been strapped to his bed constantly in order to keep him from unknowingly ripping the I.V.’s from his body.\cite{39}

The Massachusetts Supreme Court conceded that a normal person would have undergone the chemotherapy in an effort to possibly prolong life.\cite{40} Nonetheless, Saikewicz was allowed to die without the treatment in order to spare him the uniquely magnified ordeal his retarded condition would have caused.\cite{41}

A major point of difference between Saikewicz and Quinlan concerns the question as to who should make the mercy-killing decision. The Saikewicz court rejected physicians and ethics committees, holding that this decision was to be made by the courts.\cite{42}

C. Living Will Statutes

The so-called Living Will statutes (another example of Madison Avenue language instituted by the pro-euthanasia cause) first appeared in 1976 with the enactment of the California Natural Death Act.\cite{43} In view of the creation, in Quinlan and Saikewicz, of a con-

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\textit{Id.} at 730, 370 N.E.2d at 430. However, the court did not entirely avoid the quality of life issue:

\textit{Id.} at 733-54, 370 N.E.2d at 431-32.

The court went on to characterize the trial court’s use of the phrase, “quality of life” as “perhaps, an ill-chosen term.” \textit{Id.} Sigmund Freud would not agree.

\cite{39} \textit{Id.} at 750, 370 N.E.2d at 430.

\cite{40} \textit{Id.}

\cite{41} \textit{Id.}

\cite{42} \textit{Id.} at 755-59, 370 N.E.2d at 432-35.

\cite{43} \textit{CAL. HEALTH \\& SAFETY CODE} §§ 7185-95 (West Supp. 1976). The emotionally tempting, but logically unrelated phrase “living will,” which describes such
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institutionally mandated obligation to terminate (a more accurate description than "right to die") it would appear that these statutes have become superfluous. However, these statutes, which allow a citizen to decide, prior to becoming incapable of making the decision, whether to terminate life-sustaining procedures have become fairly popular and have been enacted by fourteen states and the District of Columbia.

The California act, which is fairly typical, envisions that the directive to a physician should take the following form:

Directive to Physicians

Directive made this _______ day of _________ (month, year).

I, ______________, being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. I have been diagnosed and notified at least 14 days ago as having a terminal condition by ______________, M.D., whose address is ______________, and whose telephone number is ______________. I understand that if I have not filled in the physician's name and address, it

4. Since the right asserted in Quinlan, and Saikewicz is said to be of constitutional magnitude, it would seem that the hospital is now legally obligated to terminate a patient in Karen Quinlan's condition because of her "privacy right," regardless of the patient's view on the subject. See In re Quinlan, 70 N.J. 10, 40-42, 355 A.2d 647, 664 (1976). The Quinlan court disregarded recounts of expressions made by Karen, prior to the incident that rendered her unconscious, that she would like to be allowed to die, saying "such testimony is without sufficient probative weight." Id. See also id. at 22, 355 A.2d at 653.

5. Living Will statutes have been enacted in Alaska, Arkansas, California, Delaware, the District of Columbia, Idaho, Kansas, Nevada, New Mexico, North Carolina, Oregon, Texas, Vermont, Virginia, and Washington. Florida has such a right by judicial construction. See John F. Kennedy Memorial Hosp. v. Bludworth, 432 So. 2d 611, 620 (Fla. App. 1989).
shall be presumed that I did not have a terminal condition when I made this directive.

5. This directive shall have no force or effect five years from the date filled in above.

6. I understand the full import of the directive and I am emotionally and mentally competent to make this directive.

Signed ____________________________________________

City, County, and State of Residence

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness ____________________________________________

Witness ____________________________________________

The provisions of paragraphs one and four provide significantly different kinds of consent. Paragraph one operates prior to the onset of a terminal illness, while paragraph four operates after the illness has been diagnosed as terminal. Whereas the general declaration in paragraph one is merely a factor the physician may weigh in his "medical" judgment, a declaration pursuant to paragraph four is absolutely binding on the physician.

Under the California statute, the declarant must be an "adult." This provision was specifically included to eliminate vicarious consent by parents for their children or by guardians of an incompetent. As a further safeguard, the directive must be re-executed every five years to remain valid, and can be revoked at any time, even by a simple oral statement.

These statutes provide a potentially viable answer to the obvious criticisms of the Quinlan opinion's second major weak link—substituted privacy; that is granting the terminally ill patient's privacy decisions to a third party. However, even though there was a brief flurry of activity following their initial enactment, the actual use of Living Wills has declined. This decline is most likely not due to the fact that the citizenry is now opposed to euthanasia, but rather that they failed to plan for the possible occasion of its necessity. One student commentator picks up this point and argues that the mere failure to execute a Living Will should not be taken

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47. Id. § 7191(b) & (c).
48. Id. § 7194. In addition, a person may only execute such a document on his own behalf.
52. Id. at 173.
53. See infra note 56.
as a contrary declaration.\textsuperscript{54} That is, even in the states that have
authorized Living Wills, the failure of a person to execute such a
directive does not eliminate the basic Quinlan/Saikewicz obligation
to terminate. Although a harsh counter argument may be
made, i.e., because the patient had the opportunity to execute a
Living Will, it should be presumed that he intentionally by-passed
that right (an analogy to the "legislative inaction" approach to stat-
utory interpretation),\textsuperscript{55} such an approach would likely place the
law entirely out of step with reality.

III. THE ACTIVE/PASSIVE DISTINCTION

The distinction between "active" and "passive" euthanasia is
an emotional distinction, but one that is without substance. The
distinction plays upon a sense that it is somehow better to
"merely"\textsuperscript{56} let someone die, than it is to actively \textit{kill} them. It is
clear that this distinction is of some importance in criminal law,
because it is unrealistic to insist that every member of American
society will make overt sacrifices to save the lives of strangers.\textsuperscript{57}
However, it is well established even in criminal law that where a
special relationship of dependancy exists between the parties, an
affirmative obligation to act will be imputed.\textsuperscript{58} For example, al-
though a stranger has no obligation to render aid,\textsuperscript{59} a parent may
not allow its helpless child to drown in a three-foot pool of water
where the parent could step in without danger and save the child.\textsuperscript{60}

Where a person is immobilized in a hospital bed, and the situa-

\begin{footnotes}
\item[54] See Note, supra note 51, at 169-70.
\item[55] See, e.g., Alter v. Michael, 64 Cal. 2d 480, 483, 413 P.2d 153, 155, 50 Cal. Rptr. 553,
555 (1966).
\item[56] The word "mere" is an inherently anti-analytical word. Anything can be
made to sound less important, less horrifying, or less surprising by simply
placing the word "mere" before it. Compare, for example, "starvation"
(sounds pretty awful) with "mere starvation" (no one would volunteer for it,
but there must be something worse). A lawyer, judge or writer of any kind
who must resort to the use of the word "mere" to get a point across is
"merely" displaying his inability to explain, either because the speaker or
writer lacks the analytical skill or because no analytically significant point
can be made.
\item[57] See generally J. HALL, GENERAL PRINCIPALS OF CRIMINAL LAW 190-205, 208-11
(2d ed. 1960); W. LAFAVE & A. SCOTT, CRIMINAL LAW 182-191 (1972); Hughes,
\item[58] See W. LAFAVE & A. SCOTT, supra note 57, at 184 and authorities cited therein.
For example, a parent may be guilty of criminal homicide for failure to call a
doctor for his sick child. See id. at 184 n.4 (discussing cases in which parents
believing in prayer, rather than medicine, failed to call a physician).
\item[59] Id. at 184.
\item[60] Id. at 182 ("The trend of the law has been toward enlarging the scope of duty
[sic] to act."). See generally Hughes, supra note 57.
\end{footnotes}
tion involves, for example, the physician "merely" disconnecting an I.V. or pulling the plug on resuscitory machinery, the physician's affirmative duty is even stronger than that of the parent to a child.

The active/passive distinction is being employed by euthanasia proponents because of its emotional appeal. If alleviating suffering is the goal of the pro-euthanasia cause, the passive approach is, of course, counterproductive since there will be many situations where a simple affirmative act by the physician could euthanatize the patient with much less pain. Therefore, although the tenor of this Article opposes euthanasia, it may be appropriate, if society as a whole decides to embrace the position so as to permit active euthanasia to reduce needless suffering. The use of passive euthanasia, however, perpetuates society's acceptance of mercy-killing. Therefore, the passive approach will become obsolete. The temporary presence of passive euthanasia on the emotional horizon ought not to be used, like the proverbial salesman's foot, to wedge open the door leading to the acceptance of active euthanasia.

A similarly meaningless distinction is sometimes made between so-called "ordinary" measures and "heroic" measures. Today's heroic measures will be tomorrow's ordinary measures as society becomes acclimated to the technological advances associated with those procedures. Contrary to modern thought the use

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An infant starved to death in Chicago. Its parents did not supply it with food necessary to sustain life. No one in the block fed it. No one in Chicago fed it. There were more than one hundred and seventy million people in the United States who did not feed it.... But if the neighbors who knew about the situation were held legally chargeable with the death, there might be no end of officious meddling in other homes.


Other nations have adopted a stronger view than the American approach. For example, French law requires one to aid his fellow man when he can do so without danger to himself. See Languier, French Penal Law and the Duty to Aid Persons in Danger, 38 Tul. L. Rev. 81 (1963).

Hughes, supra note 57, at 632-34, describes similar provisions in Communist countries.

61. For example, since Karen Quinlan failed to die when disconnected from the respirator, Hyland and Baime, supra note 27, at 126 n.140, suggest an example of such a transition to a willingness to accept a greater degree of activity: "The change in [Karen's] condition has caused some to speculate whether the Quinlan decision permits the family to [now] request termination of intravenous feeding." See also In re Conroy, 190 N.J. Super. 453 (App. Div. 1983). It should be noted that Hyland and Baime (and others) have begun to refer to passive euthanasia by a new name (as if the nomenclature somehow further distinguishes it from mercy-killing)—antidysthanasia. See Hyland & Baime, supra note 27, at 126 n.140, and authorities cited therein. Aside from being considerably more difficult to pronounce, any significant difference between the words antidysthanasia and mercy-killing is certainly not apparent.
of intervenous feeding would have been deemed heroic in the recent past. Medicine marches on. For this reason it is unlikely that this distinction can ever have a fixed meaning in the rapidly changing sequence of technological progress.

For analytical purposes, the concept of "brain death" must also be eliminated from this discussion. With improvements in medical technology, the original definition of death (cessation of breathing and heartbeat) has become obsolete. In what is more a change of form than of substance, many jurisdictions have enacted brain death statutes, while other jurisdictions have reached the same result through adjudication. Therefore, it must be assumed, in view of technological advances, that the definition of death in terms of a complete cessation of brain function (flat EEG) will become the standard embraced in all jurisdictions as the question arises.

The complete brain cessation approach is clearly a reasonable redefinition of death. However, some commentators argue that the flat EEG approach is too conservative: "We consider life to include human qualities and, therefore, submit that a quadraplegic former extroverted college trampoline champion would consider himself to be, in effect, dead." However, the type of sophistry implicit in such a metaphysical expansion of the term "death," must


64. Brain death was originally proposed by two French researchers. See Mollaret & Goulon, Le Coma Depasse, 101 REV. NEUROLOGY 3 (1959). However, the Harvard group appears to have popularized the idea in the American medical community. 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).

65. Spudis & Oleck, Management of Seven Stable Levels of Brain Death, 5 J. LEGAL MED. 5, 5 (1977). It should also be noted that much of the discussion of Quinlan has focused on the possibility that Karen was defined as "already dead," although it is clearly had too much brain activity to be considered dead by any accepted standard. See Hyland & Balme, supra note 27.
be avoided because it would simply constitute euthanasia by a different name.

IV. THE CASE FOR THE PRESERVATION OF LIFE

The case for the preservation of life can be broken down into twelve basic component arguments. The arguments in their totality, including their synergistic interaction, present a realistic picture of the dangers and drawbacks of the superficially attractive process of euthanasia.

A. Deterrence Without Punishment

Prior to the Quinlan decision, it was clear that euthanasia was condemned as murder by the American legal system. It is clear, however, that acts of euthanasia occurred. As with any crime, the deterrent value of the law is not infinite. In 1959, Professor Kamisar surveyed the euthanasia cases actually brought to trial and found that juries rarely, if ever, convicted the indicted party. Thus, euthanasia’s status as murder under the criminal law operated in what might be considered an ideal fashion: those who contemplated committing euthanasia were strongly deterred by the danger of punishment for such a serious crime as murder; and yet, when circumstances were so grave and desperate as to negate the deterrent effect, no punishment followed. The fear of prosecution, in effect, was an excellent selection device. This fear insured that in order for loved ones to be willing to commit euthanasia, they would have to be so certain of its necessity that they would, in desperation, risk prosecution for murder.

More importantly, keeping euthanasia illegal “on the books” served the important purpose of reinforcing social values. However, the social attitude against euthanasia bolstered the deterrent

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66. See Kamisar, supra note 3, at 970 (“The law on the books condemns all mercy killings.”).

67. Id. at 971-73. Kamisar’s thesis that a law may work ideally when it strikes the correct balance between deterrence and disobedience was excellently set forth in a more general context:

Most laws are introduced with the expectation that they will sometimes be broken, but it is generally thought that noncompliance diminishes the utility of laws. It is possible, however, to design laws the utility of which is actually enhanced by a certain amount of noncompliance.

... Thus, laws should be constructed not as if they are to function in a society in which universal compliance will occur, but should be formulated to achieve the best results under the level of compliance that is expected to prevail.

accomplishments of the law: those who would euthanatize their loved ones would have to be not only so desperate as to risk prosecution, but also so desperate as to overcome the moral struggle within themselves that grew out of the well-institutionalized social values favoring the sanctity of life.

The concession inherent in this argument is that some extreme situations warrant a decision in favor of euthanasia. Thus, the circular reinforcing effect of murder statutes and societal norms could break down. However, the murder statutes' inherent selection process operates in a placebo-like sense to restrict euthanasia to the most sincerely desperate cases. A patient who is told of the nature of his placebo will not likely respond to its intended psychological effect. Thus, because the public was generally unaware of the lack of punishment, the statutes acted to screen out all but the most extreme cases of euthanasia.

B. The Rational Choice

Proposals for euthanasia68 begin with an acceptance of the premise of “voluntary” euthanasia. Voluntary euthanasia, simply defined, occurs when the patient, who is terminally ill and in great pain, makes his own decision to be euthanatized. Certainly, after the not-so-voluntary acts of euthanasia that took place under the Nazi government during World War II, voluntary euthanasia is, on the surface, the only socially acceptable proposal. However, the concept of such a choice being made by the patient who is a candidate for euthanasia has been questioned. In a now somewhat classic phrase, Dr. Frohman suggests that, by definition, such a person must be crazed with pain, yet sane enough to make the most important decision of his life.69 Obviously, if the patient is not in severe pain, there is no desperate need to euthanatize him.70 Thus,

68. See, e.g., A. Downing, Euthanasia and the Right to Death (1969); J. Fletcher, Morals and Medicine (1954); J. Sullivan, The Morality of Mercy-Killing (1950); Banks, Euthanasia, 161 Prac. 101 (1948); Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Integrity of Life, 26 Rutgers L. Rev. 228 (1973); Gurney, Is There A Right to Die?—A Study of The Law of Euthanasia, 3 Cum.-Sam. L. Rev. 235 (1972); Sharpe & Hargest, Lifesaving Treatment for Unwilling Patients, 36 Fordham L. Rev. 695 (1968); Wechsler & Michael, A Rationale of the Law of Homocide: I, 37 Colum. L. Rev. 701 (1937); Note, Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy, 69 Cornell L. Rev. 363 (1984). Certainly an exhaustive listing is not intended here. However, from the sheer volume of such publications, it may be inferred that euthanasia requires a great deal of "selling" to make it acceptable.


70. The only argument for euthanatizing a comatose patient, for example, is to save the money being paid for medical bills. There are, of course, some who
there is an inherent contradiction in the concept of voluntary euthanasia. Opponents of euthanasia are not simply nitpicking with its proponents on the technical issue of when consent is legally acceptable. Instead, the opponents contend that the concept of individual consent to voluntary euthanasia is entirely insincere and that it is used merely as a vehicle to slowly sell involuntary euthanasia.

Another problem regarding the idea of rational choice in a voluntary euthanasia situation is inherent in the finality of the decision. Certainly, people change their minds, and those who are ill and restricted to bed are prey to significant ups and downs in their emotions:

Assuming for the purpose of argument, that the occasion when a euthanasia candidate possesses a sufficiently clear mind can be ascertained and that a request for euthanasia is then made, there remain other problems. The mind of the pain-racked may occasionally be clear, but is it not also likely to be uncertain and variable? Lord Horder, in the House of Lords debates:

During the morning depression he [the patient] will be found to favor the application under this Bill, later in the day he will think quite differently, or will have forgotten all about it. The mental clarity with which noble Lords who present this bill are able to think and to speak must not be thought to have any counterpart in the alternating and confused judgments of the sick man. 71

Unfortunately, the decision to be euthanatized is not one that can be reversed. Thus, a patient who does not wish to be euthanatized on seven occasions but decides to choose euthanasia on the eighth, will never have a ninth. It is not idle speculation to consider the possibility that had that ninth occasion occurred, the patient might have changed his mind.

At first glance, it appears that many of these objections are unbelievable in euthanatizing patients to save money. See infra notes 106 & 112 and accompanying text.

Surprisingly, one of the post Quinlan-Saikewicz cases, while relying on the comatose patient's right to privacy, candidly admits that the patient has no interest in the outcome! See John F. Kennedy Memorial Hosp. v. Bludworth, 432 So. 2d 611, 615 (Fla. App. 1983) ("Every court that has considered a similar situation has concluded that a terminally ill comatose patient, like his fully conscious and competent counterpart, has a right to refuse medical treatment.") Not seeing any inconsistency, that court conceded:

"[W]e may assume that in the case of a comatose individual there is no pain and suffering (philosophical considerations aside), then it would seem to follow that the direct beneficiary of the request is the family of the patient and that the benefits are financial savings and cessation of the emotional drain occasioned by awaiting the medico-legal death of a loved one."

Id. at 618 (emphasis added).

71. Kamisar, supra note 3, at 988.
answered by the Living Will concept. Under this statutory scheme, the patient makes the decision at a time when he is still well enough to make such a rational choice. Yet, how many decisions made in advance are rejected when the time comes to go through with them? Professor Kamisar makes this point clear by analogy to a classic Aesop's fable:

It was a bitter-cold day in the wintertime, and an old man was gathering broken branches in the forest to make a fire at home. The branches were covered with ice, and many of them were frozen and had to be pulled apart, and his discomfort was intense. Finally the poor old fellow became so thoroughly wrought up by his suffering that he called loudly upon death to come. To his surprise, Death came at once, and asked what he wanted. Very hastily the old man replied, "Oh nothing, except to help me carry this bundle of sticks home so that I may make a fire."72

C. Medical Error

There is a tendency among doctors to look upon themselves as gods, and, even worse, a tendency of the lay populace (including lawyers) to be foolish enough to accept the image. It is, however, sobering to reflect upon the degree to which the lay public believes that the legal profession also possesses an almost mystical degree of knowledge. Yet, the Chief Justice of the Supreme Court recently asserted that one third of the attorneys practicing today are incompetent.73 Lawyers who make a point of keeping up to date in even a few fields wonder why the distinguished Chief Justice picked so low a percentage.74 Somehow, however, lawyers fail to

72. Kamisar, supra note 3, at 989 n.56 (quoting Walsh, Life is Sacred, 94 FORUM 333, 333-34 (1955)).

The inherent value of life and the frightening status of death have varied over the course of history. Obviously, when the early Romans were enjoying watching gladiators being killed and Christians being fed to the lions, an extreme view of the value of human life was in vogue. Although it may be a biased opinion, the fact that human life is considered so vital that it cannot be meaningfully reflected upon in the hypothetical context seems a tribute to our degree of civilization.

73. Address by Chief Justice Burger, The Fourth John F. Sonnet Memorial Lecture at Fordham University Law School (Nov. 26, 1973). See also Address by Chief Justice Burger, American Bar Association Mid-Year Conference, Chicago, Ill. (1978). The figures quoted by the Chief Justice varied from one-third to one-half, and he noted that some of the judges he had spoken to felt that 75 percent of the practicing attorneys they worked with were incompetent.

74. One may also wonder why the Chief Justice did not include a higher percentage for the judiciary. The author, a civil procedure professor, is constantly bombarded with requests for advice on procedural matters from the bench and Bar. Candor compels the comment that a first year student who did not know the answers to many of these questions would fail civil procedure. Consider, for example, a state court trial judge with over ten years' judicial experience who did not understand that there are constitutional limits on a
wonder about the related percentage of incompetence among their fellow professionals—the physicians.\textsuperscript{75} It is the physician who informs the patient that he is terminally ill, and whose decisions are accepted with enough certainty and confidence to permit the patient to choose euthanasia.

Medicine never was and, at least for some time, will not be an exact science. There is obviously room for error, but the ramifications of that room for error are exacerbated in the context of the terminally ill patient. Here the physician, who perceives himself to be a god-like character, finds himself frustratingly helpless to work the all-important, god-like miracle his patient so badly needs. There are deep-rooted psychological dynamics involved in such a situation, which certainly vary from physician to physician; but these dynamics are only likely to further impair the already limited ability of the physician to save lives.

The ultimate decision as to whether euthanasia, in the rare, appropriate cases, has so much value that it is worth the risk of mistakes by physicians, is a matter of personal judgment. However, this problem must be taken into account, along with the other criticisms that have been and will be suggested when facing the ultimate question of whether euthanasia's advantages exceed its numerous drawbacks. It may be noted that these drawbacks are somewhat synergistically interrelated. Thus, as society begins to accept euthanasia (a dangerous situation for reasons discussed below), the decision to terminate life becomes an easier and more routine choice for the fallible physician to make, and increased medical errors will result.

\section*{D. The Contradictions Inherent in Safeguards}

In response to the criticisms previously discussed, proponents of euthanasia may point out that safeguards designed to substantially reduce the dangers of mercy-killing are feasible. For example, a patient who wishes to be terminated would first have to be declared terminally ill by his physician and a process of additional physician verification would have to be employed.\textsuperscript{76} In addition, a

\textsuperscript{75} Analogies between the percentage of incompetent lawyers and the percentage of incompetent doctors yield frightening results. Keep in mind that physicians, practicing at the time of this writing, who are in their late fifties, received their medical education in the 1940's. Hopefully physicians make a greater effort to stay abreast of developments than their lawyer counterparts.

For details on medical error, see generally D. Crane, The Sanctity of Social Life: Physicians' Treatment of Critically Ill Patients (1975).

\textsuperscript{76} See Kamisar, supra note 3, at 978-79.
proposal to alleviate the danger of a patient later changing his mind would be to have a patient, who wishes to be killed, affirm that desire repeatedly over a set period of time before qualifying. However, such “safeguards” necessarily prolong the process of euthanizing the terminally ill patient and make the process additionally painful, so as to virtually negate any value euthanasia provides.

When Kamisar made the argument that euthanasia is inherently problematic, he anticipated that the proponents of euthanasia would attack him as disingenuous. He thus characterized himself, from their view, as an “obstructionist.” Although Kamisar contends that the process is prone to error because it lacks sufficient safeguards, and he objects when safeguards are proposed, he then raises the argument to a third analytical level. He places the blame for an unworkable system of euthanasia on the fact that the concept of euthanasia, itself, has built-in contradictions. The process is inherently one that must be accurate to a level commensurate with the drastic nature of its action, and yet must be swift and painless. A swift, painless, and nearly perfect procedure for making such difficult and amorphous judgments is simply beyond the power of mere mortals. If mercy-killing is to be accepted, it must be accepted with the knowledge that there will be either risks of error or a drawn out process.

A partial answer to Kamisar’s argument might be found in some balanced middle ground between the two extremes. Such compromises, however, like many other legislative compromises, it is feared, would produce the benefits of neither extreme and the drawbacks of both. Such a result is especially true in view of the anticipated impact of societal acclimation to the concept and use of euthanasia. What today may be viewed as a drastic decision warranting the greatest of care at each of a few slightly safeguarded steps, will all too soon become routine—a mere matter of obtaining the signatures of those installed to effectuate the bureaucratic procedure. Controlling substance through procedure is a difficult if not impossible task, as students of, for example, administrative

77. Id. at 978.
78. Id. at 978-79. Professor Kamisar notes:

I venture to say there are few men indeed who will not so much as smile at the portion of the American Society’s Bill [citations omitted], which provides that if the petition for euthanasia shall be denied by a [trial judge], “an appeal may be taken to the appellate division of the supreme court, and/or to the Court of Appeals.”

Id. at 978 n.33.

79. Id. at 981. The word “obstructionist” was italicized in Williams’ book. See G. WILLIAMS, supra note 3, at 334.
law certainly know.  

E. The "Sails of Rescue"

In the famous lifeboat-cannibalism cases studied in basic criminal law, one of the arguments made against cannibalism is phrased in terms of the potential for the "sails of rescue" to appear unexpectedly on the horizon at any time. The "sails of rescue" analogy also applies to the terminally ill patient, because today's terminal illness may be curable tomorrow, next week, or next year. For example, enormous strides are being made toward the cure of previously fatal cancers; and, while less dramatic than the instantaneous cure for polio achieved in the 1950's, these advances are no less substantial in their impact. The chances for medical progress, if a patient's life is prolonged for even six months, are substantial. Who would be comfortable with making the decision to terminate a loved one's life only to find that a cure was subsequently discovered?

Although Kamisar characterized the "sails of rescue" as "utilitarian," it is really a "greatest good for the greatest number" approach. The "sails of rescue" argument, standing alone, will not end the euthanasia controversy, but it signifies a substantial tragic danger to be weighed against the perceived value of mercy-killing.

F. Hidden Conflicts in the Decisionmaking Process

In the effort to market euthanasia to the public, the discussion of voluntary euthanasia has been focused on the assumption that a terminally ill patient is free from some very important conflicts of interest in his decision to be terminated. It is erroneously assumed, for example, that it is only the patient's pain that will motivate his decision to commit euthanasia. Kamisar argues that it is often the suffering of the patient's loved ones and the frustration of

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81. See, e.g., S. CARTER, E. GLATSTEIN & R. LIVINGSTON, PRINCIPLES OF CANCER TREATMENT 13 (1982). See also the following pamphlets prepared by the office of Cancer Communications, National Cancer Institute: Progress Against Cancer of the Larynx (Oct. 1980); Progress Against Cancer of the Testes (Oct. 1980); Progress Against Cancer of the Uterus (Oct. 1976); Progress Against Hodgkin's Disease (1976); Progress Against Leukemias, Lymphomas, and Multiple Myeloma (June 1982).

82. Kamisar, supra note 3, at 974.
his physicians that motivate the patient to choose euthanasia. Even worse, Kamisar suggests, people might begin to take the substantial cost of prolonged medical care into account, and choose to be killed for lack of money. The potential is great for a terminally ill patient to feel overpowering guilt about the great strain he places on the financial resources of the family because of what may come to be perceived as an unnecessary prolongation of life. Today, both the cost of medical treatment and the suffering of third parties might be considered important values to be weighed when choosing euthanasia. However, euthanasia should then be proposed with those factors as candid considerations. No advocate of euthanasia to date has been willing to draw the battle lines in such hostile territory.

G. Societal Damage

When Kamisar wrote about euthanasia in 1958, the nation was still basically unified in its condemnation of mercy-killing. However, moving society from a clear dedication to preservation of life to accepting killing under certain circumstances risks blurring the lines of certain important social values. When the first step on a new path is taken, it must be asked what the second and third steps will be. Today's "impossible" has a tendency to become tomorrow's "probable," the next day's "ordinary," and finally, the "expected." As Justice Cardozo once stated, "the half truths of one generation tend at times to perpetuate themselves in the law as the whole truths of another." Put simply, there is a fear that mercy-killing will only initially be accepted in very narrowly drawn and carefully chosen contexts because of the high societal regard for the value of life. Although these initial decisions will be made with great care and determination, the extreme and abhorrent choice will be considered only in the most disastrous circumstances, the choices involved in mercy-

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83. Id. at 991. For a surprisingly candid admission of monetary motives, see John F. Kennedy Memorial Hosp. v. Bludworth, 432 So. 2d 611 (Fla. App. 1983). See also supra note 70.

killing decisions will not lend themselves to the drawing of clear lines. As society becomes accustomed to the killing, and as the value of the preservation of life declines, the safeguard of abhorrence toward the process will break down. Mercy-killing will become a normal, accepted choice of medical treatment. Careful decisions will become routine decisions.

Because the most likely candidate for mercy killing is a terminally ill person who is suffering great, needless pain, it soon becomes evident that inexorable decisions involving the quality of life must be made. Thus, the question is raised: When is the quality of life so impaired as to mandate killing? In a free society, it ought not be suggested that there are questions that should not be asked. The argument presented here is not that mankind cannot survive the questions surrounding euthanasia. Rather, mankind cannot naively assume that today’s answer will remain fixed in the future. There are times when the law must apply a “bright line” approach and, unfortunately, risk inflexibility for the sake of clarity of purpose.

An interesting insight into the criticism of the “bright line” approach is supplied by Professor Friedman. She has written on amniocentesis, the process of testing for genetic defects in a fetus while abortion is still possible:

At least one legal expert believes that any mandatory screening or prenatal diagnosis program will inevitably result in compulsory abortion legislation. He reasons that “those [found to be carriers] who reject the ever more popular solution of abortion [will] appear more and more to be recalcitrants. . . .” But retardation cannot be “wiped out,” because it is defined in relative terms. If all those presently defined as retarded are wished out of sight tomorrow, then society would simply turn its attention to a new group to whom it would give the same label . . . .

H. The Danger that Voluntary Euthanasia Proposals Will be Used to Gain Acceptance for Involuntary Euthanasia

There is a significant danger that, as voluntary mercy-killing is accepted and the value of the uniform preservation of life is rejected, society will begin to look with euthanatizing eyes towards those unfortunate individuals whose suffering is so great that they have no ability to make a voluntary choice to be terminated. Thus,

85. Examples of the “bright-line” approach come from varying areas of law. For example, in order to avoid jurisdictional squabbles, the new Court of Appeals for the Federal Circuit has jurisdiction over all cases with any patent claims. See generally Cihlar & Goldstein, A Dialogue About Potential Issues in the Patent Jurisdiction of the Court of Appeals for the Federal Circuit, 10 A.P.L.A. Q.J. 284 (1982).

involuntary euthanasia is the consequence of the first step down the slippery slope of voluntary euthanasia.

However, in this context, even the slippery slope argument is too simple. The first step proposed by the mercy-killers simply does not exist as a significant factor.\(^7\) As discussed previously, the patient who is capable of making a voluntary choice does not, by definition, qualify for the narrowly drawn and carefully applied mercy-killing proposal. Although Professor Kamisar argues that the slide down the slope begins when the first step toward euthanasia is taken, his real point is, or ought to be, that the first step does not exist; in reality the first step is a jump into a chasm. Voluntary euthanasia is simply a "bait and switch" sales device. If mercy-killing is to be accepted for what it is, its proponents should candidly advocate involuntary euthanasia from the beginning.\(^8\)

As pointed out earlier, the various arguments against mercy-killing are interrelated. Facing involuntary euthanasia squarely, it must be admitted that mercy-killing is essentially the business of making quality of life decisions, and that the patient will not be making those decisions. Those making the decisions will be subject to serious conflicts of interest in the decisionmaking process. The question then becomes whose pain and suffering (and financial burden) will be the motivating factor in the euthanasia decision.

I. The Danger of Abuse

In considering the wisdom of acquiring a new power over individuals' lives, the value of the use of such a power must be contrasted with the dangers of its abuse. The dangers involved take two principal forms. First, there is a danger of subtle societal pressure for increased mercy-killings through the creation of expectations.\(^9\) Second, there is a danger of overt governmental abuse. The obvious example of this second danger dates back a mere forty years to the experience of World War II, when euthanasia in Germany was originally available for only the privileged few, but

\(^7\) See infra notes 105-7 and accompanying text.

\(^8\) Kamisar most clearly presents this danger:

In 1950, Lord Chomley once again called the voluntary euthanasia bill to the attention of the House of Lords. He was most articulate, if not too discreet. . . . "Another objection is that the Bill does not go far enough, because it applies only to adults and does not apply to children who come into the world deaf, dumb and crippled, and who have a much better case than those for whom the Bill provides. That may be so, but we must go step by step."

Kamisar, supra note 3, at 1018.

\(^9\) See supra notes 61-65 and accompanying text.
gradually became the tool for extermination of the Jews. Society recoils with incredulity at the thought of such abuses today—that isn't going to happen here. It is difficult, indeed, to believe that such a terror could be repeated. It is more comfortable, and indeed probably more plausible, to smirk at such concerns and go about daily routines in comfort and security—as did the military officers stationed in Pearl Harbor on the sunny morning of December 7, 1941.

The preceding analogy is obviously melodramatic. There is no substantial proof that such serious and horrifying abuses will be repeated. But to adequately assess the negative value of possible governmental abuses, the very small probability of reoccurrence must be multiplied by the enormity of the dangers involved. A very small chance of an utterly unacceptable danger cannot be dismissed simply because of low probability.

J. Negative Impact on Research

The horror of cancer has brought about a monumental, national effort to search for cures and treatments. The tragedy of young children's bodies deteriorating from muscular dystrophy has produced the "telethon," in which entertainers, politicians, members of the clergy, and persons from all walks of life are united in the fight against a common enemy—disease. That which is horrible society fights with vehemence. However, in mercy-killing, society has found a way to ease its suffering as well as an opiate for its conscience. Mercy-killing isn't horrible. While mercy-killing is a drastic event from the perspective of the terminally ill patient, it is only temporarily drastic for those who go on living. And the physician, whose self-image of godliness is shaken by his frustrating inability to save the terminally ill patient, would see his frustrations terminated with the patient's life.

90. Id. (emphasis added, footnote omitted) (quoting 169 H.L. Deb. 551, 559 (1950)). A translation of a secret order signed by Hitler, dated September 1, 1939, introduced during the Nuremberg Trials, stated:

Reichsleiter Bouhler and Dr. Brandt, M.D. are charged with the responsibility of enlarging the authority of certain physicians . . . in such a manner that persons who, according to human judgment, are incurable can, upon a more careful diagnosis of their condition of sickness, be accorded a mercy death.

2 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL LAW No. 10, at 196 (1950). This order signaled the beginning of the extermination of the Jews. See A. Mitscherlich & F. Mielke, DOCTORS OF INFAMY 92 (1949); Kamisar, supra note 3, at 1034-35.

91. There are, of course, some who believe the chance is more substantial than portrayed here. At the time of this writing, our society is experiencing a significant turn toward conservatism and militarism, less than thirty years after its painful experience with McCarthyism.
It is obviously difficult to predict whether the acceptance of mercy-killing will, in fact, take away the stinging stimulus that now cries out for medical research. While this situation is unprecedented in modern medical history, the suffering brought by war may be analogous. World War I brought the desperate attempt to form the League of Nations. World War II gave birth to the United Nations. But a short period of peace, at least on an international scale, resulted in the complete deterioration of the promised enforcement structure of world peace. The American agony of the drawn out Vietnam War produced less than a decade of pacifism. Because American society does not mobilize in the absence of drastic pressure, the ultimate irony of the acceptance of mercy-killing would be the increased need for mercy-killing due to its effect of inhibiting the drive to find cures and treatments for the terminally ill patient.

92. The United Nations Charter provides:

All members of the United Nations, in order to contribute to the maintenance of international peace and security, undertake to make available to the Security Council, units on call and in accordance with a special agreement or agreements, armed forces, assistance, and facilities, including rights of passage, necessary for the purpose of maintaining international peace and security.

U.N. Charter art. 43, para. 1. The Charter further provides:

In order to enable the United Nations to take urgent military measures, members shall hold immediately available national air force contingents for combined international enforcement action. The strength and degree of readiness of these contingents . . . shall be determined, within the limits laid down in the special agreement or agreements referred to in Article 43 . . . .

Id. art. 45. However, no such “agreements” were ever reached, and the dream of world government by United Nations forces soon vanished. Today’s United Nations peace-keeping forces (which are generally a token force designed to enforce a truce between two fighting factions) are formed on a voluntary basis, and do not reflect the enforcement power of the Security Council. Rather, the peace-keeping forces are formed after ad-hoc action taken by the General Assembly, which may only “discuss,” “consider,” and “make recommendations.” See id. art. 10 & 11.

93. At the time of this writing, the United States had just invaded Grenada, had troops in Lebanon, and disarmament talks with the Soviet Union had broken off because of the introduction of new nuclear missiles in Europe.

94. The inability of the proponents of mercy-killing to think in terms of a dynamic technology is not surprising. Lawyers, judges, and legal scholars often seem to make proposals and law on the implicit assumption that the technological world will remain static. A classic example of this phenomenon is found in the development of the “reasonable expectation of privacy” standard for determining what activity constitutes a “search” within the meaning of the fourth amendment. See Katz v. United States, 389 U.S. 347 (1967). At what point in time, if any, are those “expectations” frozen? If we assume they are frozen into the expectations one would have had in 1791 (a logical time to choose), then the only intrusion one might expect would be a nearby listener. The Katz opinion seems to assume that the reasonableness of a per-
K. Discriminatory Mercy-Killing

Physicians, who of necessity would be the group most involved in mercy-killing decisions, are predominantly white, upper-middle class, and, although there is no statistically sound basis for making such a projection, experience suggests, politically conservative. When making the important, and yet subjective, decisions to terminate life, physicians' prejudices and biases must be taken into account.

The American system of health care can currently be criticized by the assertion that the system favors the wealthy and the socially enfranchised. The danger that the power of mercy-killing will be either consciously or, more importantly, subconsciously employed to terminate socially or racially disenfranchised patients cannot be overlooked. It is difficult to believe that public hospitals can be expected to entirely ignore the temptation to terminate a public assistance patient when the alternative is a lengthy and expensive terminal hospital stay for which he cannot pay.

A similar type of discrimination that is extremely prevalent in the context of the terminally ill patient is ageism. In recent years, groups calling themselves the "Grey Panthers" have come forward to demonstrate to a society obsessed with youth that older persons simply cannot be discarded. Yet, it is clear that physicians downgrade the value of saving older patients, and more readily declare them to be "terminal." Unfortunately, physicians often tend to lose track of broader social values as they bury themselves in scientific objectivity. To physicians, an older patient is simply a person with fewer remaining healthy years to live. However, all

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95. See, e.g., Small, Gaffing at a Thing Called Cause: Medico-Legal Conflicts in the Concept of Causation, 31 Tex. L. Rev. 631 (1953). Consider Miami Coal Co. v. Luce, 76 Ind. App. 245, 131 N.E. 824 (1921), in which a man was injured in a mine explosion. After fifteen days of misery due to extensive internal injuries, he died. In the widow's suit for compensation, the doctors testified that the "cause" of death was not the explosion, but obstructed bowels. Id. at 249, 131 N.E. at 825. Fortunately, the court intervened and interposed a "common sense" version of causation.

96. An analogy may be drawn to the medical school practice of denying older students admission on the theory that they would have less time to serve the community after graduation. While there is a simplistic logic in this approach, it overlooks broader social values, which have since been embodied in the Federal Age Discrimination Act, 42 U.S.C. § 6101 (1975). See 45 C.F.R. § 90 (1983) (Health and Human Services Regulations expressly interpreting the Act to prohibit such "longevity" of service discrimination). See also Schuck, The Graying of Civil Rights Law: The Age Discrimination Act of
members of society have an expectation of becoming “senior citizens,” and have a vested interest in dedicated health care for older patients.

L. Impact on Patient Recovery Rates

Physicians universally agree that a patient’s mental outlook significantly affects his chances for recovery. The brain can subtly, but significantly, influence the body chemistry of recovery. Put in its simplest terms, a patient who is trying to recover has the greatest chance for success. Conversely, and more importantly for the purposes of this discussion, a patient who has abandoned the effort to recover may, in so doing, sign his own death warrant. In a society that rejects mercy-killing, a patient, although labeled terminally ill, has no alternative but to strive for recovery. As mercy-killing is condoned and accepted, patients are encouraged to give up hope and thereby significantly decrease their chances for recovery. The patient and his physician must fight together to combat his disease.

V. A CRITICAL EVALUATION

The arguments against mercy-killing must be examined against society’s recent experiences with euthanasia. Persuasive legal arguments that are not accepted by society are a Pyrrhic victory. Most of the arguments against mercy-killing either cannot be, or have not to date been, definitively proven or disproven and therefore must be accepted or rejected on their persuasive value alone. For example, the validity of the argument that a person’s life might be terminated and then a cure found for his disease (the “sails of rescue” argument) has not yet been proven. Yet the degree of progress in the treatment of cancer through, for example, chemotherapy...

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1975, 89 YALE L.J. 27, 71-72 (1979). Schuck notes that “such logic would well be extended to exclude the elderly from almost all general social programs on the theory that the benefits they derive will be ephemeral relative to younger persons.” Id. at 72.

97. This is regarded as being true, at least in the absence of more direct contact with mercy-killing.

98. See, e.g., Booth, A Spontaneous Recovery from Cancer, 5 J. AM. ACAD. PSYCHOANALYSIS 207, 207-14 (1977) “[M]any cancer patients deteriorate rapidly after they have been told they have cancer because they are affected by the pessimistic attitude of the medical profession as far as the prognosis is concerned.” Id. at 208. See also Glasser, Rosenberg & Gaito, Wide spread Adenocarcinoma of the Colon with Survival of 28 Years, 241 J. A.M.A. 2542, 2542-43 (1979).

99. The United States learned the dangers of a half-hearted war effort in Viet Nam. Those who do not learn from the mistakes of history are bound to repeat them.
apy, has certainly been substantial. Thus, the validity of the “sails of rescue” argument has increased.

It is also too soon to document any noticeable effect of the availability of mercy-killing on the self-healing powers of patients. As rates of cure increase through medical progress, losses due to the decrease in desire to fight for survival may be obscured, and may never be demonstrable. Competent medical researchers should be encouraged to investigate this factor in the next decade to determine the significance of the argument. Similarly, the extreme dangers of governmental abuse of mercy-killing, for example, in eugenics-oriented programs, have not yet been demonstrated. On the other hand, even critics of the governmental abuse argument will admit that there has hardly been sufficient experience with mercy-killing to justify confidence, on an empirical basis, that the argument is unwarranted.

Significant statistical research over the next decade may prove that the argument regarding the racially and socially discriminatory mercy-killing propensities of physicians is true. Finally, although no apparent change has been observed in the dedication to research the effects of increased mercy-killing, these issues will have to remain unanswered until there is sufficient time for trends to appear. Further, on the federal level, increased military spending at the expense of domestic spending will, in the near future, tend to obscure the significance of much of the available data on these issues.100

The foregoing discussion is obviously not intended to concede the failure of these arguments. Rather, the acknowledgment must be made that none of these arguments have yet come to the forefront of the euthanasia debate through dramatic or significant demonstration. On the other hand, it should be noted that none of the arguments have been disproven by our basic experience.

Kamisar’s theory that the law in 1958 was operating ideally by restricting euthanasia through fear, yet not punishing mercy-killers in extremely drastic situations, has not been proven untrue, but it has more or less been rendered moot. Even in those jurisdictions in which the state courts have not yet rendered Quinlan or Saikewicz type decisions, the impact of the current trend toward the freedom to terminate one’s life is clear. It is difficult to believe that statutes that formally declare mercy-killing to be murder have any significant deterrent value. The lack of deterrence is related to its placebo-like nature. The deterrent value only works if the lack of punishment is not acknowledged. Thus, a choice between deter-

100. Private efforts, however, can be monitored. However, a significant period of time will be necessary before any clear trends will appear.
rence and non-punishment will eventually have to be made, and at least some punishment implemented, in order to reinstate the deterrent value if the statute is to resume operation as a highly selective screening device.

On the other hand, society's limited experience with mercy-killing has to a shocking degree validated several of the anti-euthanasia arguments. Extrapolating from such a limited sample, the potential is nothing short of horrifying. For example, as previously noted, there are inherent difficulties in a system that attempts to incorporate adequate safeguards to ensure a degree of reliability commensurate with the drastic nature of the actions involved, and at the same time operate with sufficient speed and ease to allow a painless and dignified death. Both the Quinlan and Saikewicz decisions have been plagued with these difficulties, and considerable debate has been generated in the medico-legal literature and the cases that have followed.101

In Quinlan, the court created a privacy right and then distributed it to a vast number of persons. Indeed, about the only person who did not have a say in the decisionmaking was Karen herself. However, the problem with Quinlan was that one of the safeguards worked—the ethics committee rejected mercy-killing. The Quinlans then circumvented the safeguard, thereby demonstrating the danger of abuse. The real danger may be that these decisions involve concrete answers to unanswerable questions. Therefore, because the various steps in any reasonable system of safeguards are necessarily contradictory, the process of euthanasia is paralyzed, producing neither a clear decision in favor of mercy-killing nor a clear decision against it. Any possible action toward mercy-killing or any inaction to prolong the procedure would be, in effect, abuse, at least from some perspective.

The Saikewicz approach was severely criticized by the omniscient physicians; after all, God does not hold hearings before he

101. See, e.g., Baron, Assuring "Detached But Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-Type Cases, 4 AM. J.L. & MED. 111 (1978) (agrees with the judicial dominance envisioned by Saikewicz, but prefers a more adversarial process); Buchanan, Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-Type Cases, 5 AM. J.L. & MED. 97 (1979) (poses an "alternative" view that the decision will usually be made by the family and physician, subject to some sort of ethics committee unless a Living Will has made it for the patient); Norris, Foreward, 5 AM. J.L. & MED. at i (1979); Relman, The Saikewicz Decision: A Medical Viewpoint, 4 AM. J.L. & MED. 233 (1978) (believes physicians and family should make the entire "medical" decision). Assuming such decisions will have to be made, clearly the only plausible argument is that presented by Baron, who points to insufficient judicial scrutiny in Saikewicz. But see In re Dinnerstien, 6 Mass. App. Ct. 468, 380 N.E.2d 134 (1980).
giveth or taketh away.\textsuperscript{102} In response to the Quinlan/Saikewicz controversy about euthanasia procedures, and the uproar against these procedures in the medical community, most courts have all but abandoned any attempt to establish meaningful safeguards.\textsuperscript{103} Even the Massachusetts court limited the Saikewicz approach to the very unusual circumstances of that case, and virtually abandoned that judicial model in \textit{In re Dinerstein}.\textsuperscript{104} Thus, in the frighteningly short period of time since the beginning of formally sanctioned mercy-killing, nearly all pretense of safeguards has been abandoned or circumvented.

Such an approach, however, is not to be entirely criticized, at least from one theoretical point of view. An “anti-safeguards” approach simply reflects a great deal of confidence in the medical profession. This approach attempts to whole-heartedly accomplish the goals of mercy-killing (a swift, painless process) at the expense of some danger of medical error, perceived by the mercy-killing proponents to be, more or less, a minor problem. Unfortunately, if any anti-euthanasia argument has been verified by current experience, it is the argument that medical error is a serious problem. Of course, the discovery of incidents of medical error will be, inherently, unusual events in the mercy-killing context. Once a


The most serious problem in a \textit{Saikewicz}-type hearing is the lack of any institutionalized adversary to test the pro-termination conclusion being presented to the court. In most of the early cases, the prosecutor was a named party because of the desire for declaratory relief. The prosecutor’s office, although ill-equipped and unmotivated to do so, has generally represented the state’s interest in life. Once the declaratory relief is received in the first case in a given jurisdiction, the prosecutor becomes unnecessary. In subsequent cases the only possible party for such a role is the guardian ad litem, who is usually an attorney with political connections to the court and little desire to “make waves.”

\textsuperscript{103} See \textit{In re Storar}, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, \textit{cert. denied}, 454 U.S. 858 (1981). The more thoughtful, reflective opinion of the Appellate Division was \textit{In re Eichner}, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), which had adopted the judicial model. However, \textit{Eichner} was reversed in \textit{Storar}, leaving New York with even more limited safeguards than \textit{Quinlan} provided in New Jersey.


patient's life has been terminated, it will be difficult if not impossible to prove that he would have lived. Ironically, however, in the very first case of judicially sanctioned mercy-killing Karen Quinlan did not die as predicted. Obviously, the Quinlan case alone cannot be seen as a statistically significant sample, but it is difficult to believe that in the very first case, the physicians' predictions could be so seriously wrong.105

The conflicts of interest argument—that factors other than the suffering of the patient will be considered in reaching a mercy-killing decision—has also been proven true. Who was suffering in the Quinlan case? Certainly not Karen in her comatose state. The so-called mercy-killing decision in that case was certainly not intended to end Karen's suffering. The decision ended her family's suffering. To put it bluntly, Quinlan simply was not a mercy-killing. In the harsh light of reality, the decision to terminate Karen's life was made to ease someone else's pain—hardly the charitable decision the New Jersey Supreme Court painted.106

It should be noted that the Saikewicz decision is not marred by this flaw.107 Given Saikewicz's retarded condition, he certainly would have suffered significantly had he undergone painful chemotherapy without any understanding of the consequences. It is also to be conceded that Saikewicz died as his physicians predicted. The contrast between Quinlan and Saikewicz clearly presents the troubling questions of mercy-killing. However, assuming, as no statistician would, that these two cases are typical, and knowing that serious medical errors and conflicts of interest...

105. A wrongfully terminated patient will, of course, be buried. The prediction that death will occur is the only assertion whose accuracy will be effectively tested, and even then, only where passive euthanasia is employed based upon that prediction.

106. The New Jersey Supreme Court in Quinlan wrote:

Here a loving parent, qua parent and raising the rights of his incompetent and profoundly damaged daughter, probably irreversibly doomed to no more than a biologically vegetative remnant of life, is before the court. He seeks authorization to abandon specialized technological procedures which can only maintain for a time a body having no potential for resumption or continuance of other than a "vegetative" existence.


For the contrary view of those who believe in cryonic suspension in the hope of a future life when a subsequent cure is found, see R. Nelson, We Froze the First Man (1968); Henderson & Ettinger, Cryonic Suspension and the Law, 15 UCLA L. REV. 414 (1968).

107. Problems suggested by the Article will not occur in every mercy-killing case.
will result in one out of two cases, would mercy-killing be the favored result?

The argument that voluntary euthanasia will be used as “bait and switch” fraud to sell involuntary euthanasia has been demonstrated. Neither Karen Quinlan nor Joseph Saikewicz asked to be euthanatized. In fact only a tiny minority of the cases decided have dealt with so-called voluntary mercy-killing. More important is the fact that involuntary euthanasia is being deceitfully portrayed. The *Quinlan* court, as noted previously, focused first on a privacy right that belongs to Karen Quinlan. Then, in a questionable shift, the court arranged for a “substituted decision.” Such substituted decisions are questionable because they attempt to misrepresent the nature of euthanasia. Consider the following inane argument by the *Quinlan* court:

> We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death.... We perceive no thread of logic distinguishing between such a choice which under the evidence of this case, could be made by a competent patient.

Such reasoning is analogous to designing automobile headlights that work only in the daytime.

The whole point is that if Karen were lucid, her prognosis *would* be altered, and she would not be eligible for mercy-killing. If the discussion of voluntary mercy-killing is not deceitful persuad-
sion in favor of involuntary mercy-killing, then what is its relevance in the Quinlan opinion? Every opinion following Quinlan bases its analysis on the Quinlan privacy notion. Therefore, the assumption must be made that the true nature of involuntary mercy-killing cannot be legally justified.

Finally, the argument that mercy-killing, even in originally carefully limited circumstances, will damage the moral fabric of our society, has been verified by present experiences with euthanasia. Note how even the Saikewicz court, while adamantly denying that it considered the quality of life issue, of necessity decided the case on that basis. Obviously this unacceptable line drawing cannot be avoided and the quality of life issue will inevitably continue to arise in mercy-killing decisions.

Perhaps the best example of the subtle acceptance of mercy-killing is demonstrated by the previous discussion of Living Wills. Recall that one commentator argued that the mere failure to execute a Living Will should not be considered a demonstration of the absence of such intent, but rather the possibility should be considered that the now terminally ill patient did not plan for his unfortunate demise. While this argument is quite logical, especially in view of practical experience, a degree of acceptance of the routine nature of mercy-killing is inherent in its statement.

Living Will statutes were previously favored because of the assumption that mercy-killing was the unusual and extreme course of action; at least such an extreme course of action should be available to those willing to take the well safeguarded affirmative steps necessary to effectuate mercy-killing. In less than two years, perceptions have already shifted to such a degree that affirmative action is now almost required in order for a person to ensure that heroic measures are taken to preserve his life in the event of incapacity. This is because there is no alternative “living non-will” provided for in the statutory scheme to ensure that extraordinary measures will be taken in the event of incapacitation.

This situation leads to an even greater degree of subtle social acceptance. Thus, in an incredibly short time, society’s position on the preservation of life has changed from an absolute right to an

110. For cases relying on the Quinlan reasoning, see supra note 108.
111. See supra note 38.
112. See supra notes 46-50 and accompanying text.
113. The author has been teaching seminars touching upon the present topic for five years. When the position advocated in the text, and the author’s desire to have “heroic measures” was raised in the first year’s class (1978), it met with no objection from the students. The tone of the class has gradually shifted. In more recent years, a number of students have argued that one had no right to burden society by requesting heroic measures. Although this is certainly not a statistically sound sampling technique, it is indicative of a trend.
exception in unusual circumstances, to a well-accepted process of mercy-killing, and finally to a situation where terminating life is almost an obligation expected of our society in order to conserve resources. It is doubtful that Professor Kamisar, writing in 1958, ever dreamed such a result would occur so swiftly. Even the skeptics of the "slippery slope" argument must admit that some impressive movement has taken place.

The effort of this Article has been to apply extraordinary measures in a desperate attempt to resuscitate the value of the preservation of life. However, note must be taken of significant technological trends that have undercut many of the original arguments, and sociological trends that have added to that effect. Since 1958, the number of Americans being treated in what might be described as terminal care have increased. Indeed, as one author has described, there is now "in every hospital in the country a shadowy community" of Americans in limbo between life and death.

Developments in medical technology, which were not widely available when Kamisar wrote in 1958, have drastically increased the number of persons in such terminal care situations. In other words, Kamisar's "greatest good for the greatest number" arguments have sustained a substantial shift in the numbers. With or without assistance from Quinlan or Saikewicz, a fairly well-known and substantial trend of unsanctioned mercy-killing has developed in terminal care-oriented medical circles.

However, a great deal of this extra-legal trend among terminal-care physicians is attributable to expectations of where the legal system was headed. There is still, however, the possibility that a strong legal response in future Quinlan- or Saikewicz-type cases in other jurisdictions could serve to reverse the trend. If these opinions are bolstered by sound policy-based analysis, rather than by formalistic reference to previously non-existent privacy rights, such opinions might gain sufficient moral force and legitimacy to compel substantial compliance. It is the role of lawyers and judges not only to argue the law in the traditional forums, but to mobilize the necessary constituencies to support their positions.

Coinciding with the technological developments of the 1960's and 1970's was a significant move in legal circles toward the furtherance of patient autonomy. This movement grew primarily from the area of informed consent or technical battery malpractice litigation. While this trend is not directly related to mercy-killing, and is entirely unrelated to involuntary euthanasia, it is diffi-

115. See supra note 11.
cult to conceive of the patient's right to informed consent and decisionmaking without the corresponding right to decline treatment. In some cases, the right to decline treatment would necessarily produce passive, voluntary euthanasia.

This right should not be confused with the privacy right referred to in Quinlan and its progeny. Informed patient decisionmaking is common law doctrine, a product of the "consent" element of a battery action against a physician. However, such a right to decline treatment should extend up to, but not include, the right to commit suicide. Thus, where a clearly successful treatment is available, and death would be the probable result of declining the treatment, a patient's common law autonomy should end, and society's interest in the preservation of life should take over.

The alternative of allowing patients the right to decline treatment, at least if they can voluntarily do so, is, again, superficially attractive. But the argument results in the same problems dealt with earlier. The right to terminate treatment would soon be extended to others to be exercised for the incompetent patient, as in Quinlan; and the temptation to subtly convert passive euthanasia into active euthanasia, where some affirmative act by the physician would achieve a significantly more effective and painless result, would once again arise.

VI. CONCLUSION

It is hoped that this Article will play a part in counteracting the "advertising campaign" approach being used to legitimate mercy-killing through such catchy slogans as "death with dignity." The prospect of mercy-killing is certainly, at best, a mixed blessing for the terminally ill patient. The enormous probability of medical error, the significant value of holding on to and preserving life in the hopes of finding a cure, and the danger that future mercy-killing proceedings will become routine, sloppy, and discriminatory warrant outright rejection of any such practice. Even the skeptics, gesting that patients neither want, understand, nor remember the informed consent material conveyed by physicians).

117. It is amusing to note that lawyers do not apply the same standard to their own practice. See Spiegel, Lawyering and Client Decisionmaking: Informed Consent and the Legal Profession, 128 U. Pa. L. Rev. 41 (1979). The strict "battery" analysis, of course, is not literally applicable, as there is no "touching" involved in the practice of law.

118. While many readers may not agree, this view is the author's position. For decisions supporting this position, see supra notes 18-21 and accompanying text. Cf. Tarasoff v. Regents of the University of California, 118 Cal. Rptr. 129, 137, 529 P.2d 553, 561 (1974) ("The protective privilege ends were the public peril begins.")., reh'g granted, 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 354 (1976).
however, will hopefully be convinced that the question is not as clear cut as the superficial opinions to date have made it appear.

The fears that were first voiced by Professor Kamisar in 1958, and modified or embellished here by the added objections discussed in this Article, have been, for the most part, proven true by society's very brief experiences with euthanasia. It is highly probable that mercy-killing is or will, in the near future, be used on cases that certainly had not been considered the most extreme and demanding cases a decade ago. Voluntary mercy-killing is certainly not being practiced and, indeed, experience suggests the constant references to voluntary mercy-killing are simply an attempt to divert consideration away from the real issue. The god-like physicians do make mistakes, and made a serious mistake in the first case to receive national attention. Those who look beyond the detailed and sympathetic concern afforded the initial "headline" cases can see a routine of sloppy and discriminatory decision-making, and must fear for the poor and disenfranchised patients in public hospitals. Acceptance of euthanasia for the terminally ill is even spawning acceptance of a parallel mercy-killing of the deformed newborn, and well publicized attempts to commit suicide. As today's deformed and unfit are "euthanatized," the marginally fit will become tomorrow's "unfit," and so on. When the preservation of life is abandoned, society will be drawn inexorably into dangerous questions of eugenics and the quality of life.

The problem confronted by this Article is that the first step—voluntary, passive euthanasia for the terminally ill patient—is obviously extremely attractive and, on the surface, fundamentally reasonable. As the first step is taken, however, the results of that first step must be considered. Each individual must subjectively balance the competing values involved in deciding whether the first step is worthwhile in view of its consequences. Slogans, rhetoric, and unrealistic, but well-chosen hypotheticals cannot be the core of this analysis.

119. See, e.g., The Case of Baby Jane Doe, NEWSWEEK, Nov. 28, 1983, at 45-46. The article also discussed the related case of a twelve-year-old cancer victim. Id. at 45. In response to this problem, the Department of Health and Human Services has established a toll-free, neonatal hot line and, as of November, 1983, had received 1,633 calls regarding such incidents. Id. at 46.

120. One such attempt was that of Elizabeth Bouvia, a quadriplegic cerebral palsy victim, who sought to prevent her hospital from force-feeding her. The court wisely refused to grant her the restraining order. Death, 70 A.B.A. J., Feb. 1984, at 29. "Reaching an opposite conclusion, a Syracuse, New York judge ruled on February 2, 1984, that an 85-year-old man depressed about his poor health has the right to refuse food and should not be force-fed by nursing-home attendants." When Lawyers Second-Guess Doctors, 96 U.S. NEWS & WORLD REP., Feb. 13, 1984, at 45.