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Compulsory Lifesaving Treatment for the Competent Adult

Robert M. Byrn

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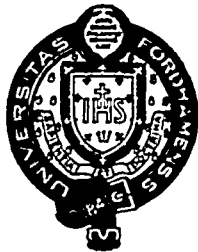
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Compulsory Lifesaving Treatment for the Competent Adult

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Professor of Law, Fordham University School of Law.

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of the materials which they purvey held
violative of equal protection clause

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Long after Rome had eclipsed, Edward Gibbon sought to isolate the essential notes that had given the Roman character its peculiar impress. He could have been describing George Bacon:

Pietas

Gravitas

Disciplina

Industria

Virtus

Clementia

Frugalitas

Severitas

I first met Professor Bacon when I was privileged to study the law of sales under him. No one would pretend that the Professor was a colorful man; but then neither was the classical Roman. Rather, he was a consummate craftsman, a meticulous scholar.

Having fought in the Rainbow Division during World War I, George returned to the Law School in 1926. His scholarly writing and conscientious teaching ability quickly made him a recognized authority in contract and sales law. His staunch New England character, his tireless guidance and counsel to student and teacher alike endeared him to Fordham men and women who first learned in his classes the intricacies of offer and acceptance, consideration, stoppage in transitu and trust receipts. He trained future judges, lawyers, law teachers, civic officials, corporate counsel and officers without pretense of fanfare and without ever losing either his humility or his New Hampshire accent.

When I came to the faculty in 1961, it was absurd for me to contemplate approaching my former professor as an equal. I never tried. Although I eventually mustered up sufficient courage to call him by his first name, to me he remained the quintessential teacher. He carefully conserved his energies for the classroom, entered it nervously each day—even after teaching contracts for forty years—and walked out spent. There is a story about Caruso. A wondering observer, watching him stroke a good-luck charm in the wings as he waited for his cue, asked: “why are you, the greatest singer of our time, so nervous?” Caruso replied: “for others one hundred percent is enough; my performance must be two hundred percent.” That is the way it was for George.

And so, we who knew him best, pause to render tribute to his memory. “For Death, He taketh all away,” but our memories of George W. Bacon He cannot take. We shall not see his like again.

Ave atque vale!

JOSEPH M. McLAUGHLIN

Dean

Ten years ago when George Bacon was vacationing at his cousin's hotel, The Shoreham, in Spring Lake, he frequently lunched at our house. One day, he said to me, "John, I have a favor to ask you. I want you to promise that you will see that the last line of my obituary reads 'He loved Fordham Law School'."

Word of his death came as a shock, followed by a nostalgic sadness. And, I regretted that the obituary in the New York Times did not respect his request.

Others will give the facts of his life, his achievements, the honors he received in his lifetime. I should like to recall the long, lazy hours, on our Spring Lake porch, which revealed so much about him.

All whom he taught and all those with whom he taught, knew him as a man of complete integrity, almost an unconscious integrity; with a keen cultivated mind, a wry, penetrating sense of humor, a unique sense of loyalty, a gentleman, spelled as two words.

His beloved Charlotte, his brother, sister-in-law and family were always in his conversation. Jefferson, New Hampshire, was part of the marrow of his bones. Repeatedly he would recall his return for Alumni Day at Fryeburg Academy in Maine, his prep school which honored him for his loyalty and achievements a few years ago.

Bowdoin College fed his New England mind, his heart and his soul. Often as he sat on the porch, reminiscing, I thought his happiest Bowdoin memory was of the time he escorted Father Robert I. Gannon from New York to Bowdoin to receive an honorary degree. When Bowdoin honored the President of Fordham, George's "cup runneth over."

Then would follow stories of Fordham Law School, "uptown," the Woolworth Building, 302 Broadway, Lincoln Center. Many were the stories of his fellow-faculty and students, for all of whom he had a deep concern and an undying devotion. He sought for, and gave to Fordham, not the better, but the best.

Everyone whom I have ever known at Fordham Law School respected and loved George Bacon with a love far greater than he ever realized. All of us at Fordham Law School loved George Bacon as deeply as: "He loved Fordham Law School."

JOHN E. MCANIFF
Adjunct Professor of Law



GEORGE W. BACON

DEDICATION

With a genuine sense of sadness, the Editors of the FORDHAM LAW REVIEW dedicate this issue to a man who was renowned and respected as a lawyer, a legal scholar and a gentleman. For over thirty years, he instructed future lawyers, judges, law professors and public officials. In view of his contribution to both Fordham Law School and this Review, it is only appropriate that the FORDHAM LAW REVIEW dedicate this issue in memoriam to Professor George W. Bacon.

COMPULSORY LIFESAVING TREATMENT FOR THE COMPETENT ADULT

ROBERT M. BYRN*

I. INTRODUCTION

A SIGNIFICANT problem in any discussion of sensitive medical-legal issues is the marked, perhaps unconscious, tendency of many to distort what the law is in pursuit of an exposition of what they would like the law to be. Nowhere is this barrier to the intelligent resolution of legal controversies more obstructive than in the debate over patient rights at the end of life. Judicial refusals to order lifesaving treatment in the face of contrary claims of bodily self-determination or free religious exercise are too often cited in support of a preconceived "right to die," even though the patients, wanting to live, have claimed no such right. Conversely, the assertion of a religious or other objection to lifesaving treatment is at times condemned as attempted suicide, even though suicide means something quite different in the law.

The purpose of this Article is to elucidate the present law and the current trends concerning the question of whether a competent, unwilling adult may be required to undergo lifesaving medical treatment. I begin with a consideration of five cases typical of the situations wherein courts, deferring to rights implicit in the American concept of personal liberty, have given priority to patient choice. In discussing these cases, I have not attempted in this first section of the Article to carry them beyond their facts and the exact language of the courts. Quite the contrary, my goal has been to provide a detailed, rigorous, and conservative critique for it is impossible to project the full sweep of the patient's right to forego lifesaving treatment without a close scrutiny of the situations in which courts have ordered the treatment.

The second section of the Article examines five decisions in which various governmental and private interests have been found sufficiently compelling to overbalance patient choice. Obviously, to the extent that these limiting decisions are valid, they define the extent of patient rights.¹

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1. Since the matter at hand always involves patients who are indisputably alive, the problem of defining death is irrelevant. See Friloux, *Death, When Does it Occur?*, 27 *Baylor L. Rev.* 10 (1975); Note, *The Time of Death—A Legal, Ethical and Medical Dilemma*, 18 *Catholic Law* 243 (1972). Also beyond the scope of this Article is the established right of a court of equity to order lifesaving treatment for a minor over parental objection. See *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769, cert. denied, 344 U.S. 824 (1952); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751, cert. denied, 371 U.S. 890 (1962); *In re Vasko*, 238 App. Div. 128, 263 N.Y.S. 552 (2d Dep't 1933).

II. THE PARAMOUNTCY OF PATIENT CHOICE: FIVE MODELS

A. *The Right of Bodily Control in a Non-emergency-Prognosis: Poor Without the Treatment*

In *Erickson v. Dilgard*,² a competent, conscious adult patient was admitted to a county hospital, suffering from intestinal bleeding. An operation was suggested, including a transfusion to replace lost blood. The transfusion was deemed necessary "to offer the best chance of recovery," in that "there was a very great chance that the patient would have little opportunity to recover without the blood."³ The patient consented to the operation but refused the transfusion. The superintendent of the hospital, in seeking an order to compel the transfusion, stated that the refusal "represented the patient's calculated decision."⁴ Although the patient's refusal was based on religious grounds,⁵ the court chose another avenue for its decision:

The County argues that it is in violation of the Penal Law to take one's own life and that as a practical matter the patient's decision not to accept blood is just about the taking of his own life. The court [does not] agree . . . because it is always a question of judgment whether the medical decision is correct. . . . [I]t is the individual who is the subject of a medical decision who has the final say [T]his must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires.⁶

Erickson has certain distinguishing characteristics. While the odds for surviving the operation were good with a transfusion and poor without it, there is no clear indication in the case of a present threat to life. There was testimony that "an operation was necessary to tie off the bleeding site," but no testimony—at least, the court referred to none—of imminent danger of death.⁷ Implicit in the court's opinion is a conclusion that the patient was not *in extremis*, and conceivably might not become so even without the treatment.⁸ Furthermore, though the odds for survival were poor, the operation might have proceeded successfully without the transfusion. Whether these conclu-

Mandated medical treatment for mental incompetents will be discussed only in so far as it is necessary to distinguish the competent from the incompetent adult patient.

2. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

3. *Id.* at 28, 252 N.Y.S.2d at 706.

4. *Id.*

5. See 33 Fordham L. Rev. 513 (1965).

6. 44 Misc. 2d at 28, 252 N.Y.S.2d at 706.

7. Some have advocated limiting the term "terminal illness" to imminent death because of unexpected remissions. Note, Informed Consent and the Dying Patient, 83 Yale L.J. 1632 n.1 (1974).

8. See also *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) where the court contrasted a "precarious" condition with a "critical" one. *Id.* at 752-53.

sions of the court were medically correct is irrelevant. They are the premises of the opinion.

In the absence of an emergency, the suicide analogy was inapposite. The court was guided by the settled principle that a competent, conscious adult patient has "the final say" on whether to submit to medical treatment. Courts have long and uniformly held that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault"⁹ The *Erickson* court obviously regarded this right as fundamental—as "necessarily so" in a system of government oriented toward personal freedom.¹⁰

A natural corollary to *Erickson* is *In re Nemser*,¹¹ wherein the court refused to order the amputation of the leg of an elderly woman when there was conflicting medical opinion as to whether the amputation would kill, cure, or merely lead to further surgery. Mrs. Nemser's competency was in doubt, but it is clear that if a court will not override patient choice to order relatively minor treatment, such as a blood transfusion, in the face of a poor prognosis, it will not order radical surgery in the face of conflicting prognoses, especially where there is evidence of substantial hazard to the patient.¹²

B. *The Right of Privacy in a Non-emergency—Prognosis: Death Without the Treatment*

*In re Yetter*¹³ presents a case where death was perhaps inevitable, but not imminent. Mrs. Yetter, a sixty year old inmate of a state mental institution, was discovered to have a breast discharge, indicating the possible presence of a carcinoma. A biopsy with corrective surgery, if necessary, was recommended. Mrs. Yetter refused, because she felt that the death of her aunt had been caused by such surgery. "[I]t was her own body and she did not desire the operation."¹⁴ Her brother petitioned for appointment as her guardian so as to consent to the surgery. At the hearing Mrs. Yetter stated that she was afraid of surgery,

9. *Schloendorff v. Society of the N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914); accord, *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Natanson v. Kline*, 186 Kan. 393, 406-07, 350 P.2d 1093, 1104 (1960); *Mohr v. Williams*, 95 Minn. 261, 268-69, 104 N.W. 12, 14-15 (1905).

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

11. 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966).

12. *Erickson* is frequently and erroneously cited as authority for the proposition that a patient in extremis will not be compelled to undergo lifesaving medical treatment. But the patient's condition was not critical. In so far as *Erickson* is concerned, that question remains open.

13. 62 Pa. D. & C.2d 619 (C.P., Northampton County Ct. 1973).

14. *Id.* at 621.

that it "might hasten the spread of the disease and do further harm" and that "she would die if surgery were performed."¹⁵

In fact, her aunt had died from unrelated causes fifteen years after breast surgery, and Mrs. Yetter, after her initial refusal, suffered from delusions concerning her problem. The court, however, found her competent, at the time of her original refusal, to understand and decide the question of the proposed surgery, and concluded that her subsequent delusions were not the primary reason for her rejection of the treatment.¹⁶

Citing the Supreme Court abortion case, *Roe v. Wade*,¹⁷ the court held:

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

There is no indication that Mrs. Yetter's condition is critical or that she is in the waning hours of life Upon reflection, balancing the risk involved in our refusal to act in favor of compulsory treatment against giving the greatest possible protection to the individual in furtherance of his own desires, we are unwilling now to overrule Mrs. Yetter's original irrational but competent decision.¹⁸

The reasoning of the *Yetter* court is cloudy in several respects. First of all, although the opinion states as a general proposition that "the right of privacy includes a right to die," subject to circumstances external to the patient which might create a compelling state interest in preventing death, this broad statement is limited by the finding that Mrs. Yetter's condition was not critical. We do not know what the court would have decided in a different case—for example, where a patient in critical condition could be saved by relatively minor treatment. The court recognized that, as a matter of common knowledge, "[t]he ordinary person's refusal to accept medical advice [may be] based upon fear"¹⁹ The court was prepared to accept, and defer to, this phenomenon. But if the patient were *in extremis*, fear of death from treatment would not ordinarily be a factor in his refusal, for instance, of a blood transfusion which would otherwise save his life.

15. *Id.* at 622.

16. *Id.*

17. 410 U.S. 113 (1973).

18. 62 Pa. D. & C.2d at 623, 624 (footnote omitted).

19. *Id.* at 624.

A second and puzzling aspect of the court's opinion is the reliance on "a right to die." Mrs. Yetter did not assert any such right but rather claimed, "it was her own body and she did not desire the operation"—a claim of right not different from that recognized in *Erickson*.²⁰ In fact, Mrs. Yetter refused treatment precisely because she feared she would die from it. The court may have meant no more by "a right to die" than in the absence of external circumstances establishing a compelling state interest, a competent adult patient is free to reject radical surgery to cure a disease which at some time may prove fatal—particularly when the refusal is based on fear of death, a "commonly known" phenomenon.

The final confusing aspect of *Yetter* is the court's resort to a right of privacy to justify a refusal of medical treatment. This same result could have been reached by invocation of the traditional right of an individual to decide what shall be done with his body, as demonstrated by the numerous tort cases which hold that a patient has a cause of action against medical personnel who perform an operation that the patient has forbidden.²¹

I have elsewhere set forth my opinion on the merits of the Supreme Court's abortion decisions.²² The specific issue of abortion is not relevant to the discussion here, but because there has been a tendency to expand the right of privacy, expounded in the abortion decisions, into other areas of the law, it is necessary to spend some time discussing the implications of these decisions on compulsory lifesaving treatment. In this context, the discussion is most enlightening when it is directed toward a comparison of the right of privacy with the right to determine what shall be done with one's body.

Probably the most frequently cited statement of the right to control one's body is from *Union Pacific Railway v. Botsford*,²³ where the Court held: "No right is . . . more sacred, or is more carefully guarded, by

20. See notes 9-10 *supra* and accompanying text.

21. *Schloendorff v. Society of the N.Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914) (operation to remove a tumor, after the patient had specifically forbidden the operation, was an "assault"); *Garzione v. Vassar Bros. Hosp.*, 36 App. Div. 2d 390, 320 N.Y.S.2d 830 (1st Dep't 1971), *aff'd*, 30 N.Y.2d 857, 286 N.E.2d 731, 335 N.Y.S.2d 293 (1972) (amputation without consent held an assault); *Pearl v. Lesnick*, 20 App. Div. 2d 761, 247 N.Y.S.2d 561 (1st Dep't 1964), *aff'd*, 19 N.Y.2d 590, 224 N.E.2d 739, 278 N.Y.S.2d 237 (1967) (radical mastectomy alleged to be an assault); accord, *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960) (dictum); *Woods v. Brumlop*, 71 N.M. 221, 377 P.2d 520 (1962) (dictum). Not one of these cases was premised on a right of privacy.

22. See Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 *Fordham L. Rev.* 807 (1973); Byrn, *The Abortion Amendments: Policy in the Light of Precedent*, 18 *St. Louis L.J.* 380 (1974).

23. 141 U.S. 250 (1891).

the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."²⁴ But even *Botsford* recognized an exception for the intimate physical examination of a condemned woman to determine if she is pregnant so as "to guard against the taking of the life of an unborn child for the crime of the mother."²⁵ There are other instances of limitation on bodily inviolability. A stop and frisk may be reasonable though it constitutes "a severe, though brief, intrusion upon cherished personal security."²⁶ Similarly a person may be required to submit to a vaccination,²⁷ or a blood sample may be extracted forcibly from the body of an individual arrested for drunken driving.²⁸

Neither the right to privacy nor the right to bodily self-determination is absolute. Both give way to more compelling governmental interests. As the Court said in *Jacobson v. Massachusetts*,²⁹ "[r]eal liberty for all could not exist under the operation of a principle which recognizes the right of each individual person to use his own, whether in respect of his person or his property, regardless of the injury that may be done to others."³⁰ The right to determine what shall be done with one's own body is limited by the potential of harm to others.

The right of privacy is similarly circumscribed. As already noted, *Yetter* premised its thesis that "the right of privacy includes a right to die" upon the Supreme Court's abortion decision.³¹ To the various

24. *Id.* at 251.

25. *Id.* at 253.

26. *Terry v. Ohio*, 392 U.S. 1, 24-25 (1968).

27. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

28. *Schmerber v. California*, 384 U.S. 757 (1966).

29. 197 U.S. 11 (1905).

30. *Id.* at 26.

31. In *Roe v. Wade*, 410 U.S. 113 (1973), and the companion case of *Doe v. Bolton*, 410 U.S. 179 (1973), the Court was faced with constitutional challenges to restrictive state abortion laws. In striking down the laws the Court held, "that the right of privacy, however based, is broad enough to cover the abortion decision; that the right, nonetheless, is not absolute and is subject to some limitations; and that at some point the state interests as to protection of health, medical standards, and prenatal life, become dominant." 410 U.S. at 155. Since the right of privacy is "fundamental," any regulation limiting the exercise of the right must be justified by a "compelling state interest." *Id.* But some regulation is permitted, and the Court rejected any theory of an absolute right of a woman to terminate her pregnancy "at whatever time, in whatever way, and for whatever reason she alone chooses." *Id.* at 153. The Court stated, "[i]n fact, it is not clear to us that the claim asserted by some amici that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions. The Court has refused to recognize an unlimited right of this kind in the past. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (vaccination); *Buck v. Bell*, 274 U.S. 200 (1927) (sterilization)." *Id.* at 154.

compelling state interests centering on the protection of others in society, *Wade* added a paternalistic interest in the protection of an individual against himself or herself. That is to say, the state may forbid an individual to engage in conduct which is hazardous to that individual's life or health. Before examining the specific holding in *Wade* concerning such state power, it is well to note that even this limitation on personal liberty is not without precedent. Statutes requiring motorcyclists to wear crash helmets come most readily to mind. The courts are split on the constitutionality of these statutes and one of the frequently litigated issues is whether a state may enact penal legislation designed not to promote or protect the welfare and safety of others, but to prevent competent adults from engaging in hazardous activities when the adults themselves are fully aware of and completely willing to assume any attendant risks. At least some courts have held such enactments to be a reasonable and valid exercise of the police power.³² There are other precedents for paternalism in the exercise of the police power. In a case upholding the constitutionality of a statute forbidding the use or handling of snakes in religious rituals, a state court opined, "that the Federal Constitution does not preclude a state from enacting a law prohibiting the practice of a religious rite which endangers the lives, health or safety of the participants, or other persons."³³ Similarly in the polygamous marriage case, the Supreme Court in dictum asked rhetorically, "[I]f a wife religiously believed it was her duty to burn herself upon the funeral pile of her dead husband, would it be beyond the power of the civil government to prevent her carrying her belief into practice?"³⁴

Given that the Court had decided to create a new "zone of privacy," the citation to *Jacobson* was to be anticipated. But *Buck v. Bell*, which upheld the constitutionality of a state statute providing for compulsory sterilization of mental defectives, had been cast in doubt by strong dicta in *Skinner v. Oklahoma*, 316 U.S. 535 (1942), which struck down as invidiously discriminatory a state statute providing for punishment by sterilization of some, but not all, theft offenders. The *Wade* Court's revival of *Buck* is somewhat surprising. Nevertheless both *Buck* and *Jacobson* have traditionally been thought of as limitations on the right of bodily self-determination. As a result of *Wade*, they also are now cast as limitations on the right of privacy indicating that the state's interest in limiting the exercise of both rights for the protection of others in society becomes compelling at the same point and for the same reasons.

32. See Annot., 32 A.L.R.3d 1270 (1970).

33. *Lawson v. Commonwealth*, 291 Ky. 437, 441-42, 164 S.W.2d 972, 974 (1942) (emphasis added).

34. *Reynolds v. United States*, 98 U.S. 145, 166 (1878). But see *Morrison v. State*, 252 S.W.2d 97, 103 (Mo. 1952) ("A religious zealot may have the right to fast until death in the sincere belief that, by so doing, God will be influenced to act positively on behalf of a sinful world . . ."). More recently, in an obscenity case, the Supreme Court stated, "[o]ur Constitution establishes a broad range of conditions on the exercise of power by the state, but for us to say that our Constitution incorporates the proposition that conduct involving consenting adults only is

There is at least some authority, therefore, for the proposition that personal liberty (whether it be bodily self-determination, privacy, or free religious exercise) is not violated by penal legislation designed to protect individuals from activities which are hazardous to life and limb despite their desire to engage in the activities with full knowledge of the risks. In this respect the *Wade* Court held that protecting the pregnant woman's own health and safety is a sufficiently compelling state interest to justify regulation of abortion after the first trimester, when the danger increases. The Court gave, as examples of appropriate regulation, those dealing with qualification and licensure of medical personnel and abortion facilities.³⁵ Does the state interest extend further? In taking cognizance of the contention that restrictive abortion laws were enacted originally to protect women, the Court did not assert that these laws were unconstitutional when enacted or that a state may not today bar a dangerous medical procedure. To the contrary, the Court stated, "[t]o restrict the legality of the abortion to the situation where it was deemed necessary, in medical judgment, for the preservation of the woman's life was only a natural conclusion in the exercise of the legislative judgment [that abortion was hazardous to the woman] of that time. A State is not to be reproached . . . for a past judgmental determination made in the light of then-existing medical knowledge."³⁶ Given its compelling interest in the preservation of the life and health of its people, a state is free to bar an elective medical procedure which is dangerous to life even though, by so doing, the state prevents competent, informed adults from choosing to run the risks of the procedure. Thus, a patient's right of privacy is subordinated in some instances, at least, to the state's paternalistic and compelling interest in preserving his life. The broad statement in *Yetter* that the right of privacy includes the right to die³⁷ must be read in the light of this state interest.

On the other hand, the crash helmet and snake-handlers cases and the Supreme Court's statements in the polygamous marriage and obscenity decisions³⁸—while they colorably support a paternalistic exercise of the police power—are all, nevertheless, couched in a negative way: hazardous conduct may be forbidden or regulated. The cases were not concerned with coercing a competent adult either actively to engage in conduct or to submit to conduct by others in

always beyond State regulation, is a step we are unable to take." *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 n.15 (1973) (citing such "constitutionally unchallenged laws" as those against suicide and self-mutilation).

35. 410 U.S. at 149-50, 163, 164.

36. *Doe v. Bolton*, 410 U.S. 179, 190 (1973); see *Roe v. Wade*, 410 U.S. at 149.

37. See notes 13-21 *supra* and accompanying text.

38. See notes 32-34 *supra* and accompanying text.

order to neutralize an existing condition which is a hazard to none but the adult. Indeed, the common law has always been hesitant to impose liability for inaction as opposed to action.³⁹ And one detects in constitutional decisions in a variety of contexts a sense of uneasiness, an intuition, that a compulsion to act contrary to individual judgment is undesirable when there is no external, compelling state interest to be served and no conflicting private right to be protected.⁴⁰

Wade spoke in terms of prohibiting or regulating action—more specifically the performance of a hazardous medical procedure. The Court did not consider whether the state's interest extended to forcing an unwilling, competent adult to undergo lifesaving treatment for his or her own good. The abortion cases are not determinative of that issue. It cannot be said that the traditional right to control one's body has been subsumed in toto under the right of privacy. The law of compulsory medical treatment is not controlled by *Wade*.

Given that the abortion decisions do not bear on the question, the court in *Yetter* would have been better advised to avoid any reference to them. The governing principle might more aptly have been stated by holding that the traditional right to determine what shall be done with one's body includes the right to refuse lifesaving treatment in a non-emergency, even when the condition may ultimately prove fatal, provided there are no facts in the particular case establishing an external compelling state interest in the continuance of the patient's life.

With the principle so stated, *Yetter* has a certain resemblance to *Erickson*. In both cases the court, deferring to the fundamental right to determine what shall be done with one's own body, gave priority to patient judgment although a reasonable patient might have chosen differently. Each opinion reflects a distrust of medical paternalism.⁴¹ The major distinction in the cases is, of course, the poor prognosis in *Erickson* as opposed to the assumed inevitability of death, albeit remote, in *Yetter*.

The right of bodily self-determination includes the right to reject medical treatment even though the patient's choice means death at

39. Binavince, *The Ethical Foundation of Criminal Liability*, 33 *Fordham L. Rev.* 1, 11 (1964).

40. E.g., *Papachristou v. City of Jacksonville*, 405 U.S. 156, 164-65, 170-71 (1972); *Board of Educ. v. Barnette*, 319 U.S. 624, 640-41 (1943); *Fenster v. Leary*, 20 N.Y.2d 309, 314-15, 229 N.E.2d 426, 429-30, 282 N.Y.S.2d 739, 744-45 (1967); cf. *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251-52 (1891).

41. A reaction against medical paternalism may also be seen in the informed consent cases, e.g., *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); see Note, *Informed Consent and the Dying Patient*, 83 *Yale L.J.* 1632, 1636-39 (1974).

some time in the future. In the next case death was not a remote inevitability. It was an imminent certainty.

C. *The Right of Free Religious Exercise in an Emergency—
Prognosis: Death Without the Treatment*

In *In re Estate of Brooks*,⁴² the court formulated the following question:

When approaching death has so weakened the mental and physical faculties of a theretofore competent adult without minor children that she may properly be said to be incompetent, may she be judicially compelled to accept treatment of a nature which will probably preserve her life, but which is forbidden by her religious convictions, and which she has previously steadfastly refused to accept, knowing death would result from such refusal?⁴³

The recommended treatment was a blood transfusion. For two years Mrs. Brooks had repeatedly informed the physician who was treating her for a peptic ulcer that her "religious and medical convictions" precluded her from receiving blood transfusions and she had gone as far as to release the doctor from liability for failing to give a transfusion. Although she was disoriented when she entered the hospital, the court obviously presumed that her prior competent refusal continued up to the point where the situation became urgent.⁴⁴

Upon petition of her doctor, the state and the county public guardian, a lower court had appointed a conservator (guardian) of the person of Mrs. Brooks and the transfusion was performed before the appeal reached the Illinois Supreme Court. Finding a substantial public interest in a resolution of the controversy despite its mootness, the court held that there was no showing that Mrs. Brooks' exercise of her religious belief "endangers, clearly and presently, the public health, welfare or morals."⁴⁵ Lacking such endangerment, the right of free religious exercise predominated. Nor would the court inquire into the reasonableness of the belief underlying the conduct.

Like the right of bodily self-determination, the right of free exercise of religion is not absolute. It gives way to a compelling state interest. But "only those interests of the highest order and those not otherwise served can overbalance legitimate claims to the free exercise of religion."⁴⁶

42. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

43. *Id.* at 365-66, 205 N.E.2d at 438.

44. Thus, the case is to be distinguished from situations where a present emergency justifies treatment of an unconscious adult under a theory of implied consent, absent evidence that the adult would have refused the treatment if conscious and aware of impending death. See note 64 *infra*.

45. 32 Ill. 2d at 372, 205 N.E.2d at 441.

46. *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972). Although Brooks has been criticized for

Again, however, the distinction must be made between forbidding one from engaging in a dangerous or fatal religious ritual (snake handling or self-destruction) and requiring one to engage in conduct or submit to conduct by others (medical treatment) in violation of religious principles, where the only interest at stake is the health and welfare of the coerced individual. "[W]e must not confuse the issue of governmental power to regulate or prohibit conduct *motivated by religious beliefs* with the quite different problem of governmental authority to compel behavior *offensive to religious principles*."⁴⁷ The *Brooks* case, in the view of the court, involved the latter problem, and the court could find no authority in government to compel the behavior.

The *Brooks* principle speaks to emergency situations, but the *Brooks* facts were such that the emergency was over because the patient had already been transfused. The life or death of the patient did not immediately hinge upon the decision of the court. Will a court react differently under such an onus?

On November 14, 1968, the New York Times reported the case of Mrs. Betty Jackson, a twenty-four year old mother of three, who suffered multiple injuries and internal bleeding following an automobile accident.⁴⁸ She was admitted to a Long Island hospital at 11:30 a.m., but despite the pleas of her doctors, her husband refused to allow a blood transfusion because both his and his wife's religion forbade it. At 4:30 p.m., a New York State Supreme Court judge denied the hospital administrator's petition for an order compelling the transfusion. Mrs. Jackson died at 6:30 p.m. No doubt the judge was tormented by the knowledge that Mrs. Jackson would most certainly die in a matter of hours without the transfusion—an agony the *Brooks* court did not have to endure. Yet he reached the same result.⁴⁹

Other courts have reacted differently when faced with the same life and death dilemma. In *Powell v. Columbian Presbyterian Medical Center*,⁵⁰ Mrs. Powell was dying. She had refused a blood transfusion

employing a "clear and present danger" rather than a "compelling state interest" test, 44 Texas L. Rev. 190, 192-93 (1965), it is difficult to imagine that the result would have been different. See *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944). Even the paternalistic interest of the state in the safety of the individual may be a sufficiently compelling interest to support a limitation on the individual's free exercise of religion. See notes 33-34 *supra* and accompanying text.

47. *Abington School Dist. v. Schempp*, 374 U.S. 203, 250 (1963) (Brennan, J., concurring) (emphasis in original).

48. N.Y. Times, Nov. 14, 1968, at 23, col. 1.

49. A like decision, with the same fatal consequences, was rendered in Milwaukee in 1972. In *re Phelps*, No. 459-207 (Milwaukee County Ct., filed July 11, 1972), discussed in Sullivan, *The Dying Person—His Plight and His Right*, 8 New England L. Rev. 197, 198-200 (1973).

50. 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965).

that would save her life, for reasons of religious belief, and "[t]here was danger that at any moment such refusal might result in her death."⁵¹ Her husband petitioned for an order compelling the transfusion. The court's agony of decision is apparent:

Never before had my judicial robe weighed so heavily on my shoulders.

.....
I knew that no release—no legalistic absolution—would absolve me or the court from responsibility if I, speaking for the court, answered "No" to the question "Am I my brother's keeper?" This woman wanted to live. I could not let her die!⁵²

The court found a way around the assertion of free exercise of religion by distinguishing between compulsion to act and compulsion to submit to the act of another. "[T]he crux of the problem lay, not in Mrs. Powell's religious convictions, but in her refusal to sign a prior written authorization for the transfusion of blood. She did not object to receiving the treatment involved—she would not, however, direct its use."⁵³ The court ordered the transfusion. In *Application of President & Directors of Georgetown College, Inc.*,⁵⁴ the court went through a similar agony of decision, and arrived at the same conclusion, using, *inter alia*, the argument that the patient objected to consenting to the transfusion—not to the transfusion itself.⁵⁵

Brooks can be profitably compared to *Erickson* and *Yetter*. While *Brooks* was premised on free exercise of religion, *Erickson* and *Yetter* expounded rights of bodily self-determination (misabeled personal pri-

51. Id. at 215, 267 N.Y.S.2d at 451.

52. Id. at 216, 267 N.Y.S.2d at 451, 452.

53. Id. at 216, 267 N.Y.S.2d at 451.

54. 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

55. Id. at 1009. The patients in *Powell* and *Georgetown College*, like the patient in *Brooks*, were Jehovah's Witnesses, a religion which believes that blood transfusions fall within the proscription of several scriptural passages forbidding the "eating of blood." 10 Vill. L. Rev. 140 n.1 (1964). The conscientious Jehovah's Witness must refuse a transfusion and resist a court order by all proper and convenient means, but not by violence. If he has done this and done all in his power to nullify the court order, he has not offended God. Id. at 140 n.3. To the extent that *Powell* and *Georgetown College* conclude that the respective patients, if transfused, would be guilty of no sin within the tenets of their faith, they seem to be theologically correct. But see *In re Osborne*, 294 A.2d 372 (D.C. Ct. App. 1972), wherein the Jehovah's Witness patient maintained that he would suffer "a loss of everlasting life" even if the transfusions were forced upon him. Id. at 375. To the extent that these decisions view the plaintiff's lack of spiritual culpability as a valid basis for compelling the transfusion, they are open to question. To interpret the nonviolence of Jehovah's Witnesses as acquiescence is wrong. Not only do they object to consenting to the transfusion, they challenge the right of a court to order it. See *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965). As Judge Burger intimated in his dissent to the denial of a petition for rehearing in *Georgetown College*, it may well be that the *Georgetown College* medical dilemma places in the hands of courts and medical personnel the power to emasculate the right of free exercise by the simple expedient of removing the onus of decision-making from the individual who asserts the right. 331 F.2d at 1017-18 (dissenting opinion).

vacy in *Yetter*) without regard to any underlying religious belief. As in *Erickson*, the objectionable procedure in *Brooks*, though not free from hazard, was relatively simple—unlike the radical surgery in *Yetter*. In neither *Erickson* nor *Yetter* was the situation urgent. Although in *Yetter* the court assumed that death was inevitable without treatment, nevertheless, the court hedged its opinion by noting that Mrs. Yetter's condition was not critical, nor was she in the waning hours of life.

The trend in the law favors *Brooks*. When there are no circumstances establishing a compelling interest in preserving the life of a competent adult patient for the welfare and safety of others, a court will not invade the religious conscience of the patient in compelling submission to medical treatment—even though the patient is in imminent danger of death and the lifesaving treatment is relatively simple and safe.⁵⁶

The *Brooks* decision speaks of free religious exercise in the context of a medical emergency. In the next case, death was imminent, and the patient's objection to treatment was not based on any religious principle.

D. *The Right to Acquiesce in Imminent and Inevitable Death—
Prognosis: Death Despite the Treatment*

Mrs. Carmen Martinez, a 72 year old Miami resident suffering from terminal hemolytic anemia, refused "cut down" transfusions and the removal of her spleen. Death was certain without treatment, but she "begged her family not to 'torture me any more' with further surgery."⁵⁷ The medical procedures might have prolonged her life, but there was no hope of a cure. In *Palm Springs General Hospital Inc. v. Martinez*,⁵⁸ her physician sought guidance as to his obligation to administer the treatment, lest he be accused of "in effect helping her to die."⁵⁹ The court ruled that Mrs. Martinez could not be forced to undergo the surgery. She died in less than a day.

Religious objections played no part in the patient's refusal of treatment. She apparently wanted to be left in peace, knowing full well that the disease from which she suffered would inevitably cause death. The court honored her decision, competently made. In so doing,

56. See notes 48-49 *supra* and accompanying text. See also *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972); *In re Osborne*, 294 A.2d 372, 374 (D.C. Ct. App. 1972). *Contra*, *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965); *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 584, 279 A.2d 670, 674 (1971).

57. *Wash. Post*, Jul. 5, 1971, at A10, col. 1.

58. *Palm Springs Gen. Hosp., Inc. v. Martinez*, Civil No. 71-12687 (Dade County Cir. Ct., filed July 2, 1971).

59. *Wash. Post*, Jul. 5, 1971, at A10, col. 2.

the court confirmed accepted medical practice. As a matter of course, valuable hospital and medical resources are not expended upon a terminal patient who no longer desires arduous life-prolonging treatment which offers, at best, a brief reprieve from death.⁶⁰

It remains to determine what right Mrs. Martinez was asserting when she refused further treatment. The answer is implicit in the language of the court:

Based upon [her] debilitated physical condition . . . and the fact that performance of surgery . . . and administration of further blood transfusions would only result in the painful extension of her life for a short period of time, it is not in the interest of justice for this Court of Equity to order that she be kept alive against her will. A conscious adult patient who is mentally competent has the right to refuse medical treatment, even when the best medical opinion deems it essential to save her life.⁶¹

Since the court expressly relied on *Erickson*, there is no doubt as to the right at issue. The right to acquiesce in imminent and inevitable death is no more than a corollary of the right to determine what shall be done with one's own body.

The carefully circumscribed language of the *Martinez* court is a caveat against overextension. The *Yetter* court was wrong in extrapolating a "right to die" from a combination of the irrelevant right of privacy and the relevant right to determine what shall be done with one's body. So too, would it be erroneous to expand the *Martinez* application of the right of bodily self-determination into a broad right to die by whatever means one may choose.

In *Erickson*, *Yetter*, and *Brooks*, the patients, although in varying degrees of danger and asserting different rights, all wanted to live and the recommended treatment promised a cure for their ills. Mrs. Martinez wanted to acquiesce in a death which no treatment could prevent. Next we consider a case in which the patient presumably wanted the treatment which would save his life but another objected.

E. Patient-Implied Consent vs. Next of Kin Nonconsent in an Emergency—Prognosis: Death Without the Treatment

Last November, newspapers in New York City reported the case of one Harry Murray, a critically wounded, unconscious adult, awaiting "a desperately needed operation" while two women argued over which was his wife. One woman consented to the operation and the other

60. Sharpe & Hargest, *Lifesaving Treatment for Unwilling Patients*, 36 *Fordham L. Rev.* 695, 700 (1968). In accord with *Martinez*, see *In re Raasch*, No. 455-996 (Milwaukee County Ct., filed Jan. 25, 1972), discussed Sullivan, *The Dying Person—His Plight and His Right*, 8 *New England L. Rev.* 197, 198, 205 (1973).

61. *Palm Springs Gen. Hosp., Inc. v. Martinez*, No. 71-12687 (Dade County Cir. Ct., filed July 2, 1971), citing *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

refused.⁶² Unanimous consent was finally obtained after the hospital sought court permission for the procedure.⁶³ It is difficult to understand why the consent of the spouse is necessary in such situations.⁶⁴ The relationship of husband and wife, without more, does not confer authority to make a binding decision on the administration of emergency lifesaving treatment.⁶⁵

A different question arises when the spouse's refusal to consent expresses the wishes of the unconscious patient. If there is a barrier to treatment, it is the patient's nonconsent, not the refusal of his spouse.⁶⁶ Mr. Murray presumably wanted to live and desired the treatment that would heal the condition which threatened him. No third party had a right to interfere.

F. *The Five Models: In Sum*

The five models are not exhaustive of all situations where the validity of compulsory lifesaving medical treatment for a competent adult may come into issue. They do typify the five situations in which the issue has been raised and in which courts, in the absence of an overbalancing state interest, have given priority to patient choice. The relevant fundamental patient rights—all concomitants of the American

62. N.Y. Post, Nov. 19, 1974, at 13, col. 1.

63. *Id.*

64. There is a universally accepted principle that a present emergency justifies treatment of an unconscious, but previously competent adult, under a theory of implied consent, at least when there is no evidence that the adult would have refused the treatment if conscious and aware of impending death. See W. Prosser, Torts § 18, at 103 (4th ed. 1971); Restatement (Second) of Torts § 62, Illustration 3 (1965); N.Y. Pub. Health Law § 2504(3) (McKinney Supp. 1974).

65. Karp v. Cooley, 493 F.2d 408, 421 (5th Cir.), cert. denied, 419 U.S. 845 (1974); Application of Pres. & Dirs. of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

66. In *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964), a wife refused to consent to an operation deemed immediately necessary to save her comatose husband's life. There were no religious objections to the procedure nor was there any indication that the wife's decision was evidentiary of the patient's choice, although the court did distinguish *Erickson* on the ground that the patient there was at all times conscious. The *Collins* court, in ordering treatment, made no comment on the efficacy of the wife's refusal but instead stressed the hospital's legal dilemma. See notes 145-61 *infra* and accompanying text.

N.Y. Pub. Health Law § 2504(3) (McKinney Supp. 1974) provides: "Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health." The clear inference is that consent of a third person is required for lifesaving treatment only if the patient is a minor or has a "legal guardian," and even then, only if there is time. No mention is made of a spouse. Unless a spouse's refusal to consent is based on the unconscious patient's own previously expressed desires, it would seem to be irrelevant in emergency situations.

concept of personal liberty—are: (1) the right to determine what shall be done with one's body in *Erickson*, *Yetter* and *Murray*, and its corollary, the right to acquiesce in imminent and inevitable death, as in *Martinez*; and (2) the right of free exercise of religion, in *Brooks*. As we have seen, it is misleading to characterize any of these as a right to die.

As a general rule the exercise of any right may be limited if it conflicts with compelling state interests, at least where there are no less drastic means available to accomplish the state purpose. A consideration of the cases in which a state interest has been held to overbalance the competent adult's decision to forego medical treatment will facilitate a projection, beyond the five models presented, of a more comprehensive set of situations wherein patient choice should be paramount.

III. THE SUBORDINATION OF PATIENT CHOICE: FIVE MODELS

A. *The State Interest in Preventing Suicide*

Since ignominious burial and forfeiture of goods have been abolished as forms of punishment in the United States, suicide, not being punishable, is not strictly speaking a crime. In some American jurisdictions attempted suicide remains criminal.⁶⁷ Even in those states that no longer punish attempted suicide, there is a recognized privilege to use reasonable force to prevent another from committing suicide or inflicting serious harm upon himself.⁶⁸ Is it possible to analogize the refusal of lifesaving treatment to an attempt at suicide or self-inflicted injury so that saving action by another is justified?

The answer requires some examination of the common law. From the earliest times, the law of suicide dealt with cases in which an individual (*felo de se*) purposefully set in motion a death-producing agent with the specific intent of effecting his own destruction or, at least, serious injury. Suicide was *malum in se*, the equivalent of murder.⁶⁹

Thus, "in legal acceptance and in popular use, the word suicide is employed to characterize . . . 'the act of designedly destroying one's

67. See W. LaFave & A. Scott, *Criminal Law* 568-69 (1972). In New York and many states, aiding and abetting a suicide or an attempt is a crime. E.g., N.Y. Penal Law §§ 120.30, 120.35, 125.15(3), 125.25(1)(b) (McKinney 1975); see W. LaFave & A. Scott, *supra*, at 570-71.

68. See, e.g., Conn. Gen. Stat. Ann. § 53a-18(4) (Ann. 1972); N.Y. Penal Law § 35.10(4) (McKinney 1975); Model Penal Code § 3.07(5) (1962); Comment, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 Calif. L. Rev. 860, 869 (1965).

69. Mikell, *Is Suicide Murder?*, 3 Colum. L. Rev. 379 (1903). "[A]s to the quality of the offence . . . it is in a degree of murder, and not of homicide or manslaughter, for homicide is the killing a man feloniously without malice prepense. . . . And here the killing of himself was prepensed and resolved in his mind before the act was done." *Hales v. Petit*, 75 Eng. Rep. 387, 399 (C.B. 1562).

own life, committed by a person of years of discretion and of sound mind.' ”⁷⁰

When an individual actively inflicts injuries upon himself in an attempt to take his own life, a justification for coerced medical treatment may be that the patient's refusal is an extension of the suicide attempt, and the medical procedures a privileged interference with the attempt.⁷¹ Otherwise, given its elements of active causation and specific intent to end life, suicide would seem to have little application to a competent adult's refusal of lifesaving medical treatment. The confusion of the two probably had its genesis in Emile Durkheim's nineteenth century non-legal definition of suicide, which was predicated on the assumption that an “objective” analysis of ethical and social phenomena could take no account of so “intimate a thing” as specific intent.⁷² Durkheim defined suicide as “all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result.”⁷³ Obviously this is not the common law definition. Yet it was the one unwittingly adopted by the court in *John F. Kennedy Memorial Hospital v. Heston*.⁷⁴

Delores Heston, aged 22 and unmarried, was severely injured in an automobile accident. She was taken to the plaintiff hospital where it was determined that surgery and a blood transfusion would be necessary to save her life. She was disoriented and incoherent, but her mother informed the hospital that the patient and the family, as Jehovah's Witnesses, were opposed to the transfusion, but not to the surgery. Upon petition of the hospital, a guardian was appointed to consent to the transfusion. Surgery was performed and the patient recovered.

As in *Brooks*,⁷⁵ the highest court of the state rendered its opinion after the transfusion had been administered. In affirming the denial of a motion to vacate the guardianship order, the court observed:

[T]here is no constitutional right to choose to die. Attempted suicide was a crime at common law It is now denounced [in New Jersey] as a disorderly persons offense.

Nor is constitutional right established by adding that one's religious faith ordains his death.⁷⁶

70. Connecticut Mut. Life Ins. Co. v. Groom, 86 Pa. 92, 97 (1878). See also 83 C.J.S. Suicide § 1 (1953).

71. Cf. Myer v. Supreme Lodge, 178 N.Y. 63, 70 N.E. 111 (1904), aff'd, 198 U.S. 508 (1905).

72. E. Durkheim, Suicide 42-43 (1951).

73. Id. at 44 (emphasis omitted).

74. 58 N.J. 576, 279 A.2d 670 (1971).

75. See notes 42-47 *supra* and accompanying text.

76. 58 N.J. at 580, 279 A.2d at 672.

The answer, of course, is that suicide at common law required a specific intent to die. Miss Heston did not want to die; she did not "claim a right to choose to die," nor did her religious faith "ordain" her death. Had the court resorted to the genuine common law test of specific intent, rather than unwittingly espousing Durkheim's theory, it would have perceived that an indispensable element of common law suicide was lacking.

Having set up the strawman of a "right to die," the court proceeded to knock it down: "Appellant suggests there is a difference between passively submitting to death and actively seeking it. The distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug. If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other."⁷⁷ Not only did the court impute a purpose to Miss Heston which she did not have ("an adult sought death"), it also failed to appreciate the second component of common law suicide—that the individual has purposefully set in motion the death-producing agent. Whether in other areas of law his conduct be called misfeasance or nonfeasance, the person who starts out to starve himself to death has no doubt deliberately set in motion the agency of his own destruction. Miss Heston had not. For this reason too her conduct cannot be called attempted suicide.⁷⁸

The court in *Application of President & Directors of Georgetown College, Inc.*,⁷⁹ made a mistake similar to that of the *Heston* court. In *Georgetown College* it was said that in states where attempted suicide is not unlawful by statute, the refusal of necessary medical aid is lawful; whereas in states where attempted suicide is unlawful, lifesaving medical assistance may be compelled. "Only quibbles about the distinction between misfeasance and nonfeasance, or the specific intent necessary to be guilty of attempted suicide, could be raised against this latter conclusion."⁸⁰ As to the first proposition, the failure to outlaw attempted suicide does not make it lawful in the sense that a right has been conferred. The existence of a privilege to prevent the suicide attempt is conclusive on that point. As to the second proposition, the well-established elements of attempted suicide should not be dismissed by pejoratives like "quibbles" in order to accommodate a non-legal definition.

Both *Heston* and *Georgetown College* are *contra* to *Brooks*, but

77. *Id.* at 581-82, 279 A.2d at 672-73.

78. See generally Ford, *Refusal of Blood Transfusions by Jehovah's Witnesses*, 10 *Catholic Law* 212, 214-16 (1964).

79. 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

80. *Id.* at 1009.

Brooks represents the trend in the law. In all three cases, the patient undoubtedly wanted to live, and the distinction from suicide—especially considering the patient's religious motivation—is clear. Suicide was also not a problem in either *Erickson*,⁸¹ where the patient wanted to live and the prognosis, though poor, was not of death, or in *Yetter*,⁸² where the patient refused treatment because she believed it would cause her death. The active causation and specific intent components of suicide were absent in each case. In *Murray*⁸³ the patient presumably wanted the treatment. And in *Martinez*,⁸⁴ the patient, though willing to acquiesce in the inevitability of early death, did not set in motion the death-producing agency with the specific intent of causing her own death, nor could she have prevented her death by submitting to treatment.

More complex problems arise when one combines and permutes the facts of the five models. Consider the following hypothetical examples:

Patient *A*, an otherwise healthy athlete, requires a leg amputation. Without it he will die, perhaps immediately or at some later time, distinguishing the merely poor prognosis in *Erickson*. The amputation will cure completely the condition that threatens to cause his death, distinguishing *Martinez*. *A* does not fear the surgery itself, distinguishing *Yetter*, nor does he have religious objections, distinguishing *Brooks*. Nevertheless, he refuses, distinguishing *Murray*, because "I came into life with two legs and I'm going out with two legs."

Patient *B* is paralyzed or otherwise seriously incapacitated by a disease or injury which threatens to cause *B*'s death at some time unless he consents to medical treatment. The treatment will neutralize the condition but will not restore *B* to health. He refuses for no other reason than "I would rather die than live like this."

Patient *C* has a chronic and ultimately fatal disease. Medical treatment will enable him to live and function normally for an unpredictable period of time, but death from the existing condition is inevitable. Knowing that he is doomed by the disease, *C* refuses the treatment solely because, "I would rather go now than live in dread."

Patient *D* is elderly and in a debilitated condition. He suffers from a disease or injury which will cause death sooner or later unless cured or controlled by arduous medical treatment. Although he is a "good risk," *D* refuses treatment because, "I'm too old for all that trouble and it's too expensive for my family."

It may be argued that *A*, *B*, *C* and *D* all have chosen to die and

81. See notes 2-10 *supra* and accompanying text.

82. See notes 13-21 *supra* and accompanying text.

83. See notes 62-66 *supra* and accompanying text.

84. See notes 57-61 *supra* and accompanying text.

that in rejecting treatment, they have, by analogy to the doctrine of avoidable consequences in tort law, become intervening active causes of their own prospective deaths; hence they are attempting suicide.⁸⁵ It is submitted that an examination of the rationale of the common law crime of suicide rebuts the argument.

In *Hales v. Petit*,⁸⁶ Justice Dyer listed four objections to suicide. First, suicide is "[a]gainst nature, because it is contrary to the rules of self-preservation . . . and then to destroy one's self is contrary to nature, and a thing most horrible."⁸⁷ In a modern, right-oriented society, the "unnatural" quality of suicide is translatable into the apparent contradiction inherent in a claim of right to destroy the life from which all rights flow.⁸⁸ But it must be apparent that *A*, *B*, *C* and *D* have not set out to "destroy" or "extinguish" their lives or to "execute" themselves. They do not claim a right of affirmative self-destruction but a right, in a sense, to allow "nature" to take its course. It is not they, but the natural progress of their ills, which will destroy their lives. Their conduct manifests a kind of pacifism, a fatalistic attitude far removed from the "extreme forms of aggression"⁸⁹ of the suicidal person who makes war on his own life. Where there is no claim of a right positively to extinguish that from which all rights flow, nor a right to kill *contra* to nature, their conduct is essentially different from suicide.

Secondly, suicide is "[a]gainst God, in that it is a breach of His commandment, *thou shalt not kill*."⁹⁰ In modern law, the commandment finds a modified, secular counterpart in the value placed upon the life of a human being, *qua* human, no matter how burdensome or burdened that life may be.⁹¹ It may be argued, with at least some validity, that actively killing oneself disvalues human life, *qua* human, because it constitutes aggression against life. Suicide treats human life as property which may be destroyed or alienated at the will of the "owner," contrary to the

85. "Psychiatric reports indicated the patient showed a lack of concern for life, and a somewhat fatalistic attitude about his condition was described as 'a variant of suicide.'" *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965).

86. 75 Eng. Rep. 387 (C.B. 1562).

87. *Id.* at 400.

88. "An executed person has indeed 'lost the right to have rights.'" *Furman v. Georgia*, 408 U.S. 238, 290 (1972) (Brennan, J., concurring). At the other end of life, the contradiction has been noted in actions brought by a child for "wrongful birth." See *Gleitman v. Cosgrove*, 49 N.J. 22, 227 A.2d 689 (1967); *Williams v. State*, 18 N.Y.2d 481, 223 N.E.2d 343, 276 N.Y.S.2d 885 (1966).

89. A. Henry & J. Short, *Suicide and Homicide* 13 (Free Press ed. 1964).

90. 75 Eng. Rep. at 400.

91. See e.g., *In re Weberlist*, 79 Misc. 2d 753, 757, 360 N.Y.S.2d 783, 787 (Sup. Ct. 1974); *Long Island Jewish-Hillside Medical Center v. Levitt*, 73 Misc. 2d 395, 396-97, 342 N.Y.S.2d 356, 358-59 (Sup. Ct. 1973); *Blackburn v. State*, 23 Ohio St. 146, 163 (1872).

principle that since life is unalienable, one may not be allowed to cause or consent to his own destruction.⁹²

Some would argue that refusal of lifesaving treatment cheapens life in the same way, and is indistinguishable from suicide.⁹³ But *A*, *B*, *C* and *D* are not engaged in aggression against life; they are not treating their lives as private property which may be alienated or destroyed at will. Quite the contrary, their claim is to passivity so that life may run its own course. They defer to the vagaries of life. We may disagree with the morality or wisdom of what they choose to do (or more accurately, not do), but it is wrong to say that their conduct undermines society's concept of the inalienability of life. A court, in ordering a lifesaving amputation for an eighty-four year old incompetent, may wisely opine that the concern we express for human life affects the very structure of society. At the same time it can consistently assert that the operation could not have been performed had the patient been competent and unwilling to undergo it.⁹⁴

Thirdly, suicide is "[a]gainst the King in that hereby he has lost a subject . . . one of his mystical members."⁹⁵ The common law prerogative of the King has been transformed in American law into an inherent function of government. "[T]he care of human life and happiness, and not their destruction, is the first and only legitimate object of good government."⁹⁶ As a result, "[t]he life of every human being is under the protection of the law, and cannot be lawfully taken by himself, or by another with his consent, except by legal authority."⁹⁷ However, as so expressed, the governmental function of caring for life, and the corollary obligation of protecting it, extend only so far as preventing the active destruction of life.⁹⁸ *A*, *B*, *C* and *D* are not engaged in actively destroying or taking their own lives.

92. *Martin v. Commonwealth*, 184 Va. 1009, 37 S.E.2d 43 (1946). And this is so whether the act of self-destruction is prompted by the pain of mortal illness or the hurt of emotional despair. Each life, as life, is equally valued. Otherwise, can we assuredly say that recognition of a "right" actively to destroy (devalue) one's own life because it is burdened, will not provide for others, to whom the life is burdensome, a rationalization for its destruction to improve the quality of their own lives?

93. Note, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 Calif. L. Rev. 860, 867 (1965); Note, *Compulsory Medical Treatment and the Free Exercise of Religion*, 42 Indiana L.J. 386, 399-401 (1967).

94. See *Long Island Jewish-Hillside Medical Center v. Levitt*, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1974).

95. 75 Eng. Rep. at 400.

96. 16 Writings of Thomas Jefferson 310 (Lipscomb & Bergh 1903).

97. *Commonwealth v. Mink*, 123 Mass. 422, 425 (1877).

98. See *Ford, Refusal of Blood Transfusions by Jehovah's Witnesses*, 10 Catholic Law. 212, 225 (1964).

Finally, suicide is also an offense against the King, in that "the King, who has the government of the people, [takes] care that no evil example be given them"⁹⁹ Certainly it remains within the power of government to bar conduct which will encourage suicide.¹⁰⁰ To the extent that any killing invites imitation, active self-destruction may serve as an "evil example" to other susceptible members of society. But it is difficult to conceive how the individual judgments of *A*, *B*, *C* and *D* to let their lives run their courses will persuade others to seek death. In the experience of one surgeon, a seriously ill patient typically "clings to life."¹⁰¹ One person's refusal of treatment will not spur others to do the same.

Neither the actual patients in the models in Part II, above, nor the hypothetical patients *A*, *B*, *C* and *D* were attempting suicide as that term should be properly understood. Nor can interference in the competent adult's decision to forego lifesaving treatment be justified as a paternalistic exercise of the police power. Paternalism, in this respect, should be limited to preventing hazardous or fatal *acts*.¹⁰²

Because the prevention of suicide and the paternalistic exercise of the police power do not, in general, appear to provide bases for compelling a competent adult to undergo lifesaving medical treatment, we are required to re-examine the breadth and application of the rights which underpin the models in Part II, above. Various questions may be asked. Which right has the patient asserted? Does he want to live or would he rather accept death? Is the risk of death immediate? Is the proposed treatment simple or arduous, hazardous or non-hazardous? Will the treatment merely postpone inevitable death? Will the patient be, or remain incapacitated or mutilated after treatment? Despite the numerous possibilities, the principle is easily stated: Assuming no other external, compelling state interest, a patient's decision to reject treatment ought to prevail in every case, including: (a) where the prognosis is poor although life is not immediately threatened (*Erickson*); (b) where the patient wants to live, although his reasons for rejecting treatment are unreasonable (*Yetter* and *Brooks*); (c) where death is inevitable despite treatment (*Martinez* and patient *C*); and (d) where the treatment is particularly hazardous or arduous, or where the patient

99. 75 Eng. Rep. at 400.

100. See *Ritter v. Mutual Life Ins. Co.*, 169 U.S. 139, 154 (1898) (against public policy to include suicide within life insurance coverage).

101. W. Nolen, *The Making of a Surgeon* 215 (1972). "Resigning oneself to fate is not the same as seeking death. No one I've ever cared for has actually sought death, at least not openly." W. Nolen, *A Surgeon's World* 280 (1972).

102. See notes 13-56 *supra* and accompanying text.

will remain seriously incapacitated or mutilated after treatment (patient *D*, patients *A* and *B*).

What then is left? The one situation not covered involves the patient who can be treated relatively easily and inexpensively, without discomfort or hazard, in such a way that the threat of death from his condition will be eliminated, and the patient will not be incapacitated or mutilated. This patient rejects treatment only because he wants to die. Given all the factors, one might argue that the individual has technically become the active cause of his own impending death—like the person who sets out to starve himself to death. It has been said, for example, that the diabetic who refuses to take insulin is attempting suicide.¹⁰³ The assertion may be technically correct, but there are substantial practical problems in so labelling the conduct. How do we determine the patient's real motives? Does he truly want to die or is his conduct traceable to some other, albeit unreasonable, motivation like that of Mrs. Yetter? Is he old, debilitated and resigned to an early death, or young, healthy and seeking death? Should we distinguish the two? At what point may the law properly intervene—early or when the situation becomes critical?

Perhaps it is the difficulty of resolving these questions, or the rarity of the case, or both, that have persuaded some judges to make sweeping statements like, "[a]s to an adult (except possibly in the case of a contagious disease which would affect the health of others) I think there is no power to prescribe what medical treatment he shall receive, and . . . he is entitled to follow his own election, whether that election be dictated by religious belief or other considerations."¹⁰⁴

It is impossible to predict how a court would deal with the last situation. It might never come to judicial attention. Because of the rarity of the case and the overwhelming difficulties of proof, it ought not give us further pause. We can therefore formulate a rule of general application, beyond the specifics of the five models in Part II. I would state it as follows: aside from the individual with self-inflicted injuries resulting from a suicide attempt, a competent adult is free to reject lifesaving medical treatment unless some other compelling state interest overbalances his claim of right. It is as much an error to distort this freedom to include a right to commit suicide, as it is to condemn its exercise as an attempt at suicide. Rejection of lifesaving therapy

103. Perr, *Suicide Responsibility of Hospital and Psychiatrist*, 9 Clev.-Mar. L. Rev. 427, 433 (1960).

104. *People v. Pierson*, 176 N.Y. 201, 212, 68 N.E. 243, 247 (1903) (Cullen, J., concurring); accord, *In re Osborne*, 294 A.2d 372, 376 (D.C. Ct. App. 1972) (Yeagley, J., concurring).

and attempted suicide are, and should be, as different in law as the proverbial apples and oranges.

B. *The State Interest in Protecting Incompetents*

In *Long Island Jewish-Hillside Medical Center v. Levitt*,¹⁰⁵ an eighty-four year old man was admitted to plaintiff hospital with a gangrenous leg which, if not amputated, would cause his death. He was a good surgical risk, but vascular disease disabled him from making judgments and decisions concerning his own health. Emphasizing the value of the life of every human being and the necessity of maintaining society's concern for human life, the court ordered the amputation. The decision is reflective of judicial concern that the lives of the elderly, the ill, and the burdensome not be devalued. The state, as *parens patriae*, has a special duty to help the person who is mentally incompetent to make such vital decisions as whether to submit to necessary treatment.¹⁰⁶ This concern for life, along with recognition of the state's duty, has persuaded courts to order substantial surgery under circumstances where, as the court pointed out in *Levitt*, a competent adult's refusal of treatment would be binding.¹⁰⁷

By definition, an incompetent lacks the ability to choose, so that court-ordered lifesaving treatment is not the subordination of patient choice to a compelling state interest. Nevertheless, *Levitt* is appropriate for consideration of the efficacy of patient choice because it exemplifies the solicitude of the law for the right to live of the helpless. This commendable attitude sometimes unduly influences the position of the court and the medical community when an unconscious or disoriented patient is brought to a hospital in need of emergency lifesaving treatment, and the medical personnel are informed of a prior decision by the individual to forego treatment should an emergency

105. 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973).

106. In re Weberlist, 79 Misc. 2d 753, 360 N.Y.S.2d 783 (Sup. Ct. 1974).

107. When the patient (unlike Levitt) has been adjudicated an incompetent, the obligation of providing necessary medical care falls upon his committee, and the consent of the committee must be obtained. *Dale v. State*, 44 App. Div. 2d 384, 355 N.Y.S.2d 485 (3d Dep't 1974). If the committee were arbitrarily to refuse to consent, a court, upon application, would undoubtedly order the necessary procedures, using as authority decisions overriding parental rejection of treatment for minors.

Commitment to an institution does not constitute an adjudication of incompetency. If the committed person is factually capable of making a judgment on recommended therapy, courts will treat the patient's decision as one competently made. See *Winters v. Miller*, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971); *New York City Health & Hosps. Corp. v. Stein*, 70 Misc. 2d 944, 335 N.Y.S.2d 461 (Sup. Ct. 1972). The capability of making this judgment has been defined as "capacity to know and understand the nature and extent of her illness and the consequences of her refusal to consent to . . . treatment. . . ." *Id.* at 946, 335 N.Y.S.2d at 464.

occur. A conflict exists between the patient's right to reject treatment and the court's *parens patriae* concern for the lives of incompetents, given the usual implication of consent in an emergency,¹⁰⁸ and the fact that the patient's previously expressed objections were not voiced in the face of a real hazard of imminent death.

Since the choice belongs ultimately to the patient, the implication of consent is the key. It is a fiction based not on any conduct of the patient, but on an estimate of how a reasonable man would react under the circumstances.¹⁰⁹ Is the implication destroyed by a previously expressed objection to treatment?

Relevant to this question is the decision in *Application of President & Directors of Georgetown College, Inc.*¹¹⁰ In *Georgetown College*, Mrs. Jesse Jones, a twenty-five year old woman, was brought to the hospital in imminent danger of death from the loss of two-thirds of her body blood due to a ruptured ulcer. After a district court judge refused to order a transfusion, a circuit judge visited Mrs. Jones in the hospital and told her that she would die without the blood, but that there was a better than fifty percent chance of survival with it. "The only audible reply I could hear was 'Against my will.'"¹¹¹ The court concluded, "Mrs. Jones was *in extremis* and hardly *compos mentis* at the time in question; she was as little able competently to decide for herself as any child would be. Under the circumstances, it may well be the duty of a court . . . to assume the responsibility of guardianship for her, as for a child, at least to the extent of authorizing treatment to save her life."¹¹² Incompetency became another basis for ordering the treatment. It is possible to challenge the court's finding of fact of incompetence since Mrs. Jones' reply to the court's question was entirely consistent with her long-held beliefs as a Jehovah's Witness.¹¹³ But this aside, the court's decision is some authority for the proposition that the previously expressed sentiments of a patient are irrelevant when the patient has become disoriented or unconscious prior to being informed that rejection of treatment will bring imminent death.

Given the patient's fundamental right to reject treatment, the sole function of a court in this situation is to make a good faith finding with respect to what the desires of the patient would have been had he been conscious and competent.¹¹⁴ Insofar as *Georgetown College* may be

108. See note 64 *supra*.

109. W. Prosser, *Torts* § 18, at 103 (4th ed. 1971).

110. 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

111. *Id.* at 1007.

112. *Id.* at 1008 (footnote omitted).

113. See 113 U. Pa. L. Rev. 290, 294 (1964).

114. See Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 Rutgers L. Rev. 228, 231-32 n.15 (1973).

read to mean that previously articulated beliefs are irrelevant, it would be considered in error. Where: (a) the objections to a particular kind of treatment (for instance, blood transfusion in the case of Jehovah's Witnesses) or to any treatment at all (for example the faith-healing sects)¹¹⁵ are religiously motivated, (b) the evidence indicates a strong adherence to the tenets of the sect, and (c) there is no countervailing evidence of irresolution, I would urge that the usual implication of consent is destroyed, and the patient's right to reject lifesaving treatment should prevail. In other situations it would be more difficult for the court to determine the desires of the patient. Such variables as the basis, profundity and longevity of the patient's objections, his age and usual state of health, the nature and risks of the treatment, and the likelihood of medical success and return to health will all, no doubt, enter into the court's calculations. Because life hangs in the balance, it seems probable that a court, properly aware of the incalculable value of even the most burdened life, will more frequently decide in favor of the treatment. In any event, the decision must be ad hoc.

A related problem arises when an irreversibly dying patient lapses into unconsciousness. May life-prolonging medical treatment be terminated prior to actual death? *Martinez*¹¹⁶ does not govern because Mrs. Martinez was competent and capable of personally rejecting the proposed treatment. *Murray*¹¹⁷ is factually distinguishable because death could be avoided by proper treatment. Yet the two cases do offer some clue to the answer.

Regardless of her objections to further treatment, it seems likely that Mrs. Martinez did not want to be neglected completely. If she were thirsty or hungry or uncomfortable or experienced any of the other usual needs of life, she would expect to be cared for. Neglect would degrade her, and would manifest an inhumane disregard for life on the part of medical personnel.¹¹⁸ All else aside, to have failed to provide for Mrs. Martinez' routine needs would have been inexcusable. The conclusion should be the same in the case of the unconscious patient.

Mr. Murray presumably wanted to live, but his implied consent is only half of the doctor-patient relationship. The other half is the doctor's duty of reasonable care once he undertakes treatment. What can the irreversibly dying and unconscious patient reasonably expect of the doctor?

115. See Cawley, *Criminal Liability in Faith Healing*, 39 Minn. L. Rev. 48 (1954).

116. See notes 57-61 *supra* and accompanying text.

117. See notes 62-66 *supra* and accompanying text.

118. It is possible that some jurisdictions would find such conduct sufficiently outrageous to give rise to a cause of action for the mental distress caused to grieving relatives. See *Rockhill v. Pollard*, 259 Ore. 54, 485 P.2d 28 (1971) (en banc); *Grimsby v. Samson*, 85 Wash. 2d 52, 530 P.2d 291 (1975) (en banc).

Clearly the patient has no right to anticipate the continuation of therapy which will not even prolong life. Blood transfusions in the case of massive, unyielding hemorrhaging may accomplish nothing.¹¹⁹ There can be no obligation to do that which does not even buy time for the patient. Take the situation one step backwards. Patient *E*, in the last stages of a fatal and incurable disease, contracts pneumonia. Penicillin might be effective, but it is not administered—"why prolong the agony?"¹²⁰ Patient *F* has had a severe heart attack; his kidneys have ceased to function—an early death is inevitable. After consultation with *F*'s family, *F*'s doctor turns off the kidney machine.

The lives of both *E* and *F* might have been prolonged for a short period. Since the legal relationship is between the patient and the doctor, *F*'s family's consent appears to be irrelevant. Further the two cases are somewhat distinguishable in that *E*'s doctor negatively withheld treatment while *F*'s affirmatively turned off the machine. Finally the law presumes a will to live, and the law is particularly solicitous of the helpless. These are the arguments against the physicians' conduct. They are unpersuasive. The majority and best opinion is that the doctors breached no duty, either to the patients (civil liability) or to society (criminal liability) when they ceased treatment of *E* and *F*.

It is true, of course, that a doctor or hospital that undertakes the care of a patient may not abandon him.¹²¹ There are several reasons for distinguishing the conduct toward *E* and *F* from culpable abandonment.

It has been said that the physician's duty continues so long as the case requires;¹²² it is unlikely, under this standard, that discontinuance of life-prolonging measures for *E* and *F* would be held a breach of duty because the cases no longer "require" the physician's services.

In addition the physician is held to a duty of ordinary care. To require him to continue futile treatment goes beyond the demands of ordinary care. He is not required to exert his skill or expend his resources in vain. The conduct of *E*'s and *F*'s doctors is properly viewed as an omission to exert skill or expend resources involving no breach of duty because there was no want of ordinary care.¹²³

119. See W. Nolen, *The Making of a Surgeon* 270-71 (1972).

120. See *id.* at 271-72.

121. 1 D. Louisell & H. Williams, *Medical Malpractice* ¶ 8.08 (1973) [hereinafter cited as Louisell & Williams].

122. Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 *Notre Dame Law.* 1202, 1208 (1973).

123. Editorial, *When Do We Let the Patient Die?*, 68 *Annals of Internal Medicine* 695, 696-97 (1968).

Doctors also commonly understand that they are not required to do that which is useless.¹²⁴ As a result, it cannot be said that *E*'s and *F*'s doctors' conduct violated the usual standards of good medical practice.¹²⁵

Finally, futile life-prolonging measures sometimes proceed from motives not entirely admirable. One critic alleges that some patients have been kept alive in order to gain experience in the intensive-care treatment of their diseases.¹²⁶ The patient becomes a test subject while his family's depleting finances are subtly extorted by the experimenters. An unscrupulous doctor may continue to treat a hopeless case just to earn a fee.¹²⁷

In sum, moralists are generally agreed that there is no obligation to continue lifesaving efforts in a hopeless case, and no decision has been found holding a doctor liable for ceasing treatment under these circumstances.¹²⁸ All these factors compel the conclusion that *E*'s and *F*'s doctors did not culpably abandon their patients. It was the disease or injury—not their omissions—which caused death.¹²⁹

124. Ayd, *Voluntary Euthanasia: The Right to be Killed—Con*, Medical Counterpoint, June, 1970, at 12.

125. Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 Catholic U. L. Rev. 723, 736-37 (1973).

126. Ayd, *Voluntary Euthanasia: The Right to be Killed—Con*, Medical Counterpoint, June, 1970, at 16.

127. W. Nolen, *The Making of a Surgeon* 201-02 (1972).

128. Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 Notre Dame Law. 1202, 1208-09 (1973).

129. See Fletcher, *Prolonging Life*, 42 Wash. L. Rev. 999, 1004-16 (1967). Lest this conclusion be misunderstood, let us make some crucial distinctions. First, absent contrary evidence of the patient's own wishes, the medical profession has no right to terminate treatment when the patient's life can be saved. See *The Citation*, June 1, 1974, at 49 (recounting a decision in Maine ordering medical treatment for a newborn infant who was left to die). Secondly, there is a wide chasm between allowing the irreversibly dying patient to die and killing him. The duty of ordinary care does not require a doctor to engage in an exercise in futility. By the same token, it does not confer a license to kill. "Discontinuing the intravenous feedings and antibiotics, taking away the supports we use to prop up a life, is one thing; doing something to shorten a life is quite another. I have no hesitation about the first; the second is beyond me." W. Nolen, *A Surgeon's World* 279-80 (1972). The House of Delegates of the American Medical Association adopted the following statement on December 4, 1973: "The intentional termination of the life of one human being by another . . . is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.

"The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family." *Medical-Moral Newsletter*, May, 1975, at 17.

C. *The State Interest in Protecting the Medical Profession;
the Medical Profession's Interest in Protecting Itself*

In *United States v. George*,¹³⁰ the court ordered transfusions for a thirty-nine year old Jehovah's Witness, the father of four, who had refused the transfusions for religious reasons while lucid but in a physically critical condition from a bleeding ulcer. The court adopted "where applicable"¹³¹ the rationale of *Georgetown College*,¹³² various aspects of which have already been discussed, and added a further reason:

In addition to the factors weighed by Judge Wright one consideration is added to the scale. In the difficult realm of religious liberty it is often assumed only the religious conscience is imperiled. Here, however, the doctor's conscience and professional oath must also be respected. In the present case the patient voluntarily submitted himself to and insisted upon medical care. Simultaneously he sought to dictate to treating physicians a course of treatment amounting to medical malpractice. To require these doctors to ignore the mandates of their own conscience, even in the name of free religious exercise, cannot be justified under these circumstances. The patient may knowingly decline treatment, but he may not demand mistreatment.¹³³

Certainly there is nothing in professional ethics or plain logic which should require congruence between the doctor's conscience and the patient's choice. By this I do not mean that the doctor is bound by the patient's choice to do something contrary to the doctor's conscience. That is discussed below. I do mean that the patient is not bound by the doctor's conscience to do something contrary to the patient's choice, and consequently the doctor may have the right and choice to do nothing.

The law of informed consent¹³⁴ would be rendered meaningless if patient choice were subservient to conscientious medical judgment. Tort cases condemning unauthorized medical treatment as a battery,¹³⁵ or, in some instances, if there has been state action, as an invasion of constitutional rights,¹³⁶ would have to be overruled. The rule of the supremacy of the "doctor's conscience" finds no real support in law.¹³⁷

130. 239 F. Supp. 752 (D. Conn. 1965).

131. Id. at 754.

132. 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964). See notes 110-15 supra and accompanying text.

133. 239 F. Supp. at 754.

134. See Plante, An Analysis of "Informed Consent," 36 Fordham L. Rev. 639 (1968).

135. See note 21 supra.

136. See *Winters v. Miller*, 446 F.2d 65 (2d Cir.), cert. denied, 404 U.S. 985 (1971); *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972).

137. One would hope, on the other hand, that the ethics of medical practice remain life-oriented, and that the day will not arrive when doctors are forced to destroy life.

Much more difficult is the problem raised by the court's reference to "a course of treatment amounting to medical malpractice."¹³⁸ A doctor is not bound to undertake treatment of a patient even in an emergency.¹³⁹ Once treatment is undertaken, the doctor owes his patient a duty of reasonable care,¹⁴⁰ which is breached by abandoning the patient.¹⁴¹ In *Yetter*, it will be recalled that Mrs. Yetter was confined in a mental institution. The court mentioned as a factor in its decision that "the present case does not involve a patient who sought medical attention from a hospital and then attempted to restrict the institution and physicians from rendering proper medical care."¹⁴² But the involuntarily confined are also owed a duty of reasonable medical care.¹⁴³ And they may, if competent adults, reject medical treatment unless the demands of institutional security require otherwise.¹⁴⁴ If the duty of care owed by the medical profession to a competent adult patient, in combination with the adult's subsequent rejection of treatment, creates a legal dilemma it is the same dilemma whether the patient is involuntarily confined, or voluntarily seeks medical aid, or is unconscious when brought to the hospital and thereafter becomes lucid.

The dilemma arises in the following way. If unauthorized treatment is administered, the patient has an action for battery or, perhaps, for invasion of his constitutional rights. On the other hand, if the doctor and the hospital fail to treat the patient, they may be civilly liable for abandoning him. Further, a person under a duty to provide medical treatment, whose unreasonable failure to do so causes death, may also be criminally liable.¹⁴⁵ Taking the middle course is also hazardous. The doctor and the hospital might subject themselves to a claim of negligence were they to defer to patient wishes and refrain

138. 239 F. Supp. at 754. See *Application of Pres. & Dirs. of Georgetown College, Inc.*, 331 F.2d 1000, 1009 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964).

139. *Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901). In the absence of statute or regulation, e.g., N.Y. Pub. Health Law § 2805-b (McKinney Supp. 1974), neither is a hospital, although it has been held that the opening of an emergency facility may be an undertaking to treat those for whose benefit it has been established and who rely on its existence. Annot., 35 A.L.R.3d 841, 846-47 (1971).

140. See 1 *Louisell & Williams*, supra note 121, ¶ 8.08. If there are no problems of charitable immunity, the hospital may also be liable. C. Kramer, *Medical Malpractice* 21-27 (rev. ed. 1965).

141. 1 *Louisell & Williams*, supra note 121, ¶ 8.08, at 217-20.

142. In re *Yetter*, 62 Pa. D. & C.2d 619, 623 (C.P. Northampton County Ct. 1973). See notes 13-21 supra and accompanying text.

143. *Fischer v. City of Elmira*, 75 Misc. 2d 510, 347 N.Y.S.2d 770 (Sup. Ct. 1973); *O'Neil v. State*, 66 Misc. 2d 936, 323 N.Y.S.2d 56 (Ct. Cl. 1971).

144. *Runnels v. Rosendale*, 499 F.2d 733 (9th Cir. 1974).

145. *Application of Pres. & Dirs. of Georgetown College, Inc.*, 331 F.2d 1000, 1009 n.18 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964). See Annot., 100 A.L.R.2d 483 (1965).

from the forbidden treatment, for example, a blood transfusion, while performing another procedure, surgery, which is rendered more dangerous by the absence of the forbidden treatment, with consequent ill effects to the patient. A release given by the patient in this situation might be questioned on the ground that the patient was not competent at the time,¹⁴⁶ or that the release does not protect against criminal prosecution,¹⁴⁷ or that the release is against public policy.¹⁴⁸

The conclusions already reached can be of assistance in finding a way out of the dilemma. Since a competent adult has a comprehensive right to reject lifesaving treatment, the liability of the treating institution and the responsible medical personnel is narrowly circumscribed. If the patient rejects treatment entirely, the problem is simplified. His instructions prevail provided that he is competent, or if he is not, that the objections of others truly reflect his wishes and beliefs, so long as there are no compelling state interests which outbalance the patient's rights to the extent that coerced treatment is justified. If there be doubt on these questions, the doctor and the hospital must seek judicial direction on how to proceed in order to protect themselves against liability.¹⁴⁹ Full disclosure must be made, with notice to next of kin who have information on the patient's wishes, lest there be a question of fraud upon the court.¹⁵⁰ Treatment will be administered or omitted as the court directs, and the court's order protects the hospital and the doctor from liability.¹⁵¹

Additional and more vexing problems arise when the patient bars only part of the treatment. Must the doctor, on demand of his patient, operate on a ruptured ulcer and, at the same time, withhold necessary blood transfusions? It must be evident that neither a court nor a patient can dictate treatment contrary to reasonable and good faith medical judgment. Even in *Roe v. Wade*, the Court, while holding abortion to be a fundamental right, agreed that "the abortion decision and its effectuation *must be left to the medical judgment of the pregnant woman's attending physician*."¹⁵² Conversely, the general rule is that the patient's rejection of reasonable treatment relieves the doctor of liability for damages due to the failure to treat.¹⁵³ In sum,

146. *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965).

147. *Application of Pres. & Dirs. of Georgetown College, Inc.*, 331 F.2d 1000, 1009 n.18 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

148. Cf. 11 U.C.L.A.L. Rev. 639 (1964).

149. See Sharpe & Hargest, *Lifesaving Treatment for Unwilling Patients*, 36 Fordham L. Rev. 695, 696-97 (1968) (discussing the doubtfully competent patient).

150. *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125, 131 (N.D. Ill. 1972).

151. W. Prosser, *Torts* § 18, at 102 (4th ed. 1971).

152. 410 U.S. at 164 (emphasis added). See note 31 *supra*.

153. *Peterson v. Branton*, 137 Minn. 74, 162 N.W. 895 (1917); *Steele v. Woods*, 327 S.W.2d 187, 196 (Mo. 1959).

the doctor cannot be forced to treat contrary to prudent medical judgment and the patient is bound, at risk of relieving the doctor of future liability, to accept reasonable medical treatment; it follows that the doctor ought to be able to withdraw from the case without liability. It has been held that a patient's refusal to follow the reasonable instructions of his doctor is a defense to a claim of abandonment.¹⁵⁴

What of the hospital's liability in these circumstances? The hospital's duties are, in general, "to furnish the patient with diligent and skillful care, competent attendants and safe equipment."¹⁵⁵ Even if the patient's doctor is not a hospital employee, the hospital may be liable to the patient if aware of conduct by the doctor which is clearly contradictory to normal practice.¹⁵⁶ But since the patient has rejected the reasonable recommendations of a competent doctor, it cannot be said that the hospital has breached any of these duties. However, if the patient is in a precarious condition, he ought not be discharged by the hospital lest the discharge become a contributing factor to subsequent death or injury.¹⁵⁷ The conclusion from all the above is that neither the doctor nor the hospital is required to undertake a course of treatment contrary to good medical judgment. The surgeon need not operate on the bleeding ulcer if the patient rejects the necessary transfusion.

But suppose the surgeon does operate? He may decide that because the patient will certainly die without surgery, he ought to proceed even without the transfusion. Under these circumstances the additional risks must be explained to the patient. If the patient consents, he assumes the risk.¹⁵⁸ If the patient becomes disoriented or unconscious prior to the explanation being given, he cannot, of course, assume the risk. As suggested above, doubts as to competency must be resolved judicially.

The medical dilemma is a real one only in so far as it requires

154. *Roberts v. Woods*, 206 F. Supp. 579, 584-85 (S.D. Ala. 1962). Indeed, the patient may be deemed contributorily negligent for failing to follow instructions. 1 *Louisell & Williams*, *supra* note 121, ¶ 9.03, at 246 n.25.

155. C. Kramer, *Medical Malpractice* 24-25 (rev. ed. 1965). In those jurisdictions which no longer distinguish between "medical" and "administrative" acts of hospital employees, the hospital will be liable for the malpractice of its employees under a respondeat superior theory. *Id.* at 23-44.

156. *Fiorentino v. Wenger*, 19 N.Y.2d 407, 414-15, 227 N.E.2d 296, 299-300, 280 N.Y.S.2d 373, 377-79 (1967).

157. C. Kramer, *Medical Malpractice* 25 (rev. ed. 1965). Patients, apparently in extremis, have been known to recover even without the recommended treatment when the hospital continues with indicated supportive treatment. See, e.g., *In re Osborne*, 294 A.2d 372, 376 n.6 (D.C. Ct. App. 1972).

158. 1 *Louisell & Williams*, *supra* note 121, ¶ 9.02 (1973).

judicial resolution of such possibly disputed questions as competency or the existence of some overbalancing state interest, and only to the extent that some courts yet fail to appreciate that a competent adult has a right to reject lifesaving treatment, and that neither the doctor nor the hospital is required by even a dying patient's choice to act contrary to reasonable medical judgment.

In view of the numerous possibilities for liability, doctors and hospitals will, and prudently should, continue to seek judicial determination of their duties whenever a patient in precarious condition refuses lifesaving treatment—with the possible exception of a *Martinez* situation¹⁵⁹ where honoring the patient's wishes is fairly well-accepted in principle and adhered to in practice. Criticism of the medical profession for resorting to the courts¹⁶⁰ is unfair. If there is an issue of competence the court is best equipped to resolve it. If the patient's right to refuse treatment, and his willingness to sign a release, render the controversy nonjusticiable for lack of any danger of liability, let the court say so.¹⁶¹

When all is said and done, the medical dilemma is a problem of judicial fact-finding and resolution of doubts, not a substantive reason for disregarding patient choice.

D. *The State Interest in Protecting Minor Children*

In *Georgetown College*,¹⁶² the court gave as a further reason for ordering the transfusion: "[t]he patient, 25 years old, was the mother of a seven-month-old child. The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus, the people had an interest in preserving the life of this mother."¹⁶³

One author found two separate alleged state interests in this statement: (a) prevention of psychic harm to the child by loss of the parent and (b) prevention of economic harm to the state by the child's becoming a public charge.¹⁶⁴ It has been held that a pregnant woman

159. See notes 57-61 *supra* and accompanying text.

160. E.g., *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966).

161. See *Application of Pres. & Dirs. of Georgetown College, Inc.*, 331 F.2d 1000, 1015 (D.C. Cir.) (Burger, J., dissenting on denial of rehearing), cert. denied, 377 U.S. 978 (1964). Effective mechanisms are available for an expeditious and thorough inquiry and resolution. See, e.g., *In re Osborne*, 294 A.2d 372 (D.C. Ct. App. 1972).

162. 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964). See notes 110-15 *supra* and accompanying text.

163. 331 F.2d at 1008.

164. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 Rutgers L. Rev. 228, 251-54 (1973).

may be compelled to submit to a blood transfusion, contrary to her religious beliefs, when the transfusion is necessary to preserve the life of her unborn child.¹⁶⁵ In *Yetter*¹⁶⁶ and *Brooks*¹⁶⁷ the courts were careful to point out that no minor children were involved. In *George*,¹⁶⁸ the court adopted *Georgetown College*.

Without disputing *Georgetown College*, a few courts have modified it. It has been argued: "[a]t best the State's interest in preserving two spouses to care for their children instead of one seems attenuated; one wonders if it would be a stronger interest if a sole surviving parent's life were at stake, so that public guardianship of the minors became an imminent reality."¹⁶⁹

The state's interest is even more in doubt, it has been urged, when the surviving parent is in accord with the patient's decision and willing to provide for the child alone.¹⁷⁰ Perhaps this reasoning persuaded a court to decline to order lifesaving transfusions for a twenty-four year old mother of three whose husband conveyed to the court the family's religious objection to such treatment.¹⁷¹

At least within these limitations it would seem that the "minor child" interest of the state does limit the right of a competent adult to reject lifesaving treatment. Whether the rule will survive remains to be seen. It will, perhaps, be put to its ultimate test if the *parens patriae* interest is asserted in a situation wherein it is the disability, rather

165. See Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 *Fordham L. Rev.* 807, 844-49 (1973). It may be true that it is a quantum leap from this situation to *Georgetown College*. It may also be true that the economic justification is somewhat undermined by a case like *Montgomery v. Board of Retirement*, 33 *Cal. App. 3d* 447, 109 *Cal. Rptr.* 181 (5th Dist. 1973) wherein it was held that disability benefits may not be denied a recipient who refuses, for religious reasons, to undergo corrective surgery. Finally, some might agree that the dangers of psychic harm to the child and depletion of the public fisc are, respectively, speculative and de minimis. Nevertheless, no court has directly taken issue with the *Georgetown College* *parens patriae* approach.

166. See notes 13-21 *supra* and accompanying text.

167. See notes 42-47 *supra* and accompanying text.

168. See notes 130-33 *supra* and accompanying text.

169. Sharpe & Hargest, *Lifesaving Treatment for Unwilling Patients*, 36 *Fordham L. Rev.* 695, 697 (1968).

170. 113 *U. Pa. L. Rev.* 290, 294 (1964).

171. See *N.Y. Times*, Nov. 14, 1968, at 23, col. 1. In *In re Osborne*, 294 *A.2d* 372 (D.C. Ct. App. 1972), the court refused to order a transfusion of a thirty-four year old man whose wife agreed with his decision and "who had, through material provision and family and spiritual bonds, provided for the future well-being of his two children." *Id.* at 375. In *Holmes v. Silver Cross Hosp.*, 340 *F. Supp.* 125 (N.D. Ill. 1972), the court denied a motion to dismiss a complaint for violation of constitutional rights in the administration of a blood transfusion under color of law. The patient had a wife and young child, but "we presently do not have sufficient information on the status of these dependents, whether their sole support came from the decedent [patient]" *Id.* at 130.

than the death of the parent that is threatened, or where the unwilling patient, asserting a religious objection to lifesaving treatment, does not share the Jehovah's Witnesses' abhorrence of physical resistance to the mandated procedure.

E. *The State Interest in Protecting Public Health*

*Jacobson v. Massachusetts*¹⁷² involved a challenge to the validity of a conviction under a state statute authorizing a fine for an adult who "refuses or neglects" to be vaccinated as required by the statute.¹⁷³ The court found defendant's claim of an "inherent right of every freeman to care for his own body"¹⁷⁴ to be overbalanced by the interest of the state in the protection of its inhabitants from a dangerous, contagious disease.¹⁷⁵

The state interest in protecting the health of others in the community clearly justifies compulsory medical procedures to neutralize the danger of contagion from potential carriers of disease. In an unusual case the treatment may also save the life of one already infected and in danger of death. The purpose, however, is not to save the patient's life but to prevent the spread of the disease. Very little controversy surrounds the power of the state to compel lifesaving treatment in such cases.

F. *The Five Models: In Sum*

It would seem that only the state interests in the welfare of the minor child,¹⁷⁶ and the protection of the public from communicable disease¹⁷⁷ may be said, with colorable legal basis, to impinge upon the competent adult's freedom to reject lifesaving medical treatment.¹⁷⁸

IV. CONCLUSION

This Article is not a morality play. By no means did I set out to judge whether, in the scenario of a particular case, the patient's choice to forego treatment was ethically defensible. I have attempted only to

172. 197 U.S. 11 (1905).

173. *Id.* at 12.

174. *Id.* at 26.

175. *Id.* at 24-31. "The right to practice religion freely does not include liberty to expose the community . . . to communicable disease . . ." *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944) (dictum). The state interest in preventing or arresting an epidemic must not, however, be confused with unauthorized human experimentation on the victim of the disease.

176. See notes 162-71 *supra* and accompanying text.

177. See notes 172-75 *supra* and accompanying text.

178. In a particular disciplinary setting, such as jail custody, it is possible that patient choice to forego lifesaving treatment might validly be subordinated to custodial authority. "Allegations that prison medical personnel performed major surgical procedures upon the body of an inmate, without his consent and over his known objections, that were not required to preserve his life or further a compelling interest of imprisonment or prison security, may foreshadow proof of conduct violative of rights under the Fourteenth Amendment sufficient to justify judgment under the Civil Rights Act." *Runnels v. Rosendale*, 499 F.2d 733, 735 (9th Cir. 1974).

discover the law and its trends. From an examination of these I deduce the following:

First: Every competent adult is free to reject lifesaving medical treatment. This freedom is grounded, depending upon the patient's claim, either on the right to determine what shall be done with one's body or the right of free religious exercise—both fundamental rights in the American scheme of personal liberty. There is no "zone of privacy" involved.

Second: The patient's freedom of choice, like all fundamental freedoms, may be subordinated to a compelling state interest at least when there are no less drastic means available to effectuate the interest.

Third: Interference with the patient's right cannot be justified either by a claimed state interest in preventing suicide or by a paternalistic exercise of the police power. Rejection of lifesaving medical treatment, except for injuries self-inflicted in an active attempt by an individual to destroy his own life, is not an attempt at suicide. However, one cannot extrapolate a right to commit suicide from the patient's freedom to reject lifesaving medical treatment. For this reason alone it is misleading to characterize the patient's freedom as a "right to die."

Fourth: The state has a *parens patriae* interest in protecting incompetents. But the disorientation of a patient ought not be used as an excuse to thwart his objection to, and rejection of, medical treatment.

Fifth: The "medical dilemma" is neither a substantive state interest justifying coerced medical treatment nor a problem of balancing conflicting personal rights. It is merely a matter of judicial resolution of doubts on such issues as patient competency. Protection of the medical community against liability requires that doctors and hospitals have free access to the courts and expeditious direction on how to proceed whenever a patient in precarious condition rejects lifesaving treatment. But under no circumstances may medical personnel be required to engage in procedures which are contradicted by reasonable medical judgment.

Sixth: In the present state of the law, lifesaving medical treatment may be compelled to further governmental interests in preventing the spread of communicable disease and in protecting the spiritual and material welfare of minor children. As to the latter, it is possible that the interest becomes attenuated when one parent would survive and is willing to care for the child, or where the child's needs have otherwise been provided for.

Reported cases on compulsory treatment are relatively rare. Newspaper accounts of such cases are frequent enough to indicate that the problem, if not pressing, at least requires clarification. Such has been the end and aim of this Article.