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Death with Dignity: A Recommendation for Statutory Change

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NOTES

DEATH WITH DIGNITY: A RECOMMENDATION FOR STATUTORY CHANGE*

*For thou shalt sleep and never wake again
And quitting life, shall quit thy living pain.*
—Dryden**

*Do not go gentle into that good night
Rage, rage against the dying of the light.*
—Dylan Thomas***

In the 1969 session of the Florida legislature, a state representative introduced a bill to deal with the problem of the hopeless patient. This bill would have amended the Florida constitution by incorporating into section 2 of the Declaration of Rights the right "to be permitted to die with dignity."¹ Following the failure of the bill to be reported out of committee,² the legislator recast the proposal as a statute³ and prefiled it in the House of Representatives.⁴ The proposal now provides that any person may execute, with the formalities required for execution of a will,⁵ a document stating that he has exercised the right to die with dignity and directing that his life not be prolonged "beyond the point of a meaningful existence." Upon a determination by the attending physician that the patient's condition was hopeless and that he was beyond recovery, the patient's directive would be carried out by terminating all medication and any artificial means of sustaining life. If the patient were physically or mentally incapable of making such a decision, then the spouse or, in the case of an unmarried or widowed individual, a majority of those persons of first degree kinship would be permitted to request the cessation of treatment when it was unnaturally prolonging an unmeaningful existence. Finally, in the case of a patient incapable

*EDITOR'S NOTE: This note received the *Gertrude Brick Law Review Apprentice Prize* for the best student note submitted in the summer 1969 quarter.

***Lucretius' Speech Against the Fear of Death*, THE POETICAL WORKS OF JOHN DRYDEN 185 (Cambridge ed. 1909).

****Do Not Go Gentle Into That Good Night*, COLLECTED POEMS OF DYLAN THOMAS (1953).

1. Fla. H.R.J. Res. 91 (1969).

2. St. Petersburg Times, July 3, 1969, §B at 2, col. 2.

3. The legislator changed the proposal to a statute because he believed it would have a better chance of passage. Letter from Rep. Walter W. Sackett, Jr. to Howard W. Brill, Oct. 17, 1969.

4. Fla. H.R. 3184 (1969), prefiled Oct. 10, 1969. The statute concerns the question of who may make the decision regarding death with dignity and the manner in which it may be made. For details regarding the cessation of treatment, see St. Petersburg Times, Jan. 9, 1969, §B at 1, col. 1; *id.* Feb. 24, 1969, §B at 1, col. 1.

5. FLA. STAT. §731.07 (1967).

of making a decision⁶ and without relatives, three doctors would be permitted to make the request to a circuit judge. In each case, before any treatment was terminated, the doctors would have the responsibility of determining from a medical standpoint, whether all meaningful life had passed. With the exception of the last situation, this determination could only occur if the patient or his next of kin had affirmatively indicated a desire for the cessation of treatment.⁷

This note will examine several aspects of the death with dignity proposal: present law in the area and the effect of the proposed statute upon it; possibilities of achieving the same result under current law; societal attitudes toward such a proposal; and moral and individual choices regarding the nature of death.

THE CRIMINAL LAW AND HUMANITARIAN DEATH

The law does not accept humanitarian motives as a defense to homicide. If a person dies a moment earlier because of the action of a second person, homicide has occurred.⁸ *People v. Kirby*⁹ dealt with a father who had drowned his children because he thought it would be better for them "to go into eternity than to stop in this world."¹⁰ In spite of his belief that he was doing what was best for them, he was convicted of murder. Also, the fact that the individual killed would soon die anyway is not a defense against a charge of criminal homicide. In *Commonwealth v. Bowen*,¹¹ the defendant was accused of urging a fellow convict to kill himself prior to his scheduled execution in order to deny the state its spectacle. The judge instructed the jury that if the defendant had intentionally accelerated the deceased's death, he was liable for murder.¹² Neither invitation nor consent is a valid defense

6. For a discussion of the situation arising when the patient has asked the doctor to use all available treatment, see text accompanying notes 48-52 *infra*.

7. This proposal is distinguished from various euthanasia bills in that euthanasia requires a positive act to end life while the present proposal merely calls for the cessation of treatment. Second, voluntary euthanasia requires the patient to consciously request the fatal treatment, as contrasted with the situation where the patient is unable to consent and the relatives must decide. Third, the euthanasia proposals have often been accused of allowing one to request death merely if the patient is in great pain or is suffering from an incapacitation that forces him to be totally dependent on others. The death with dignity proposal is limited to those beyond any hope of recovery. G. WILLIAMS, *THE SANCITY OF LIFE AND THE CRIMINAL LAW* 293-302 (1958).

8. B. SHARTEL & M. PLANT, *THE LAW OF MEDICAL PRACTICE* 370 (1959). See also G. WILLIAMS, *supra* note 7, at 289.

9. 2 Park. Crim. Rep. 28 (N.Y. 1823). See Annot., 25 A.L.R. 1007 (1923). See also *Repouille v. United States*, 165 F.2d 152 (2d Cir. 1947), where the petitioner, who was seeking to reverse a denial of citizenship, had used chloroform to kill his thirteen-year old son—whom the court described as a "monster." Since petitioner had been convicted of second degree manslaughter, Judge Learned Hand concluded that he was lacking the "good moral character" required for citizenship.

10. *People v. Kirby*, 2 Park. Crim. Rep. 28, 29 (N.Y. 1823).

11. 13 Mass. 356 (1816).

12. *Id.* at 360.

against a charge of homicide.¹³ Finally, necessity, even in extreme circumstances where the defendant had to choose between killing a nonassailant and dying himself, has not been recognized by the courts.¹⁴

Although it is well established that a physician is not insulated from criminal sanctions if he causes a patient's death,¹⁵ various medical situations in which a doctor may intentionally shorten the life of an incurably ill patient to allow death with dignity demand a reevaluation of the scope of this rule. The questionable merit of the blanket application of the concept that holds physicians liable in all circumstances is illustrated by *State v. Sander*.¹⁶ There the defendant physician admitted injecting forty cubic centimeters of air into the bloodstream of a suffering, hopelessly ill cancer patient whose death resulted less than ten minutes after the injection. Commission of euthanasia by the deliberate administration of some toxic substance to the patient renders the physician liable for first degree murder regardless of the doctor's humanitarian motives, the wishes of the decedent's relatives, or even the patient's consent.

Even where the doctor, recognizing a patient's suffering, makes poison or extra sleeping pills accessible to the patient who then administers the fatal dose himself, the well-intentioned physician may find himself guilty of murder. In *People v. Roberts*¹⁷ the defendant was found guilty of first degree murder because he had prepared poison and placed it near his wife, who was incurably ill and helpless with multiple sclerosis. The court gave no legal significance to the fact that he had made the poison available to his wife solely for the purpose of ending her suffering.

In contrast with those cases where the doctor's act is calculated to cause death are those where the drugs administered precipitate death as a side effect. For example, a doctor may give a patient a dose of morphine to ease his suffering. The efficacy of this drug will probably decline with continued use, and it may be necessary to increase the dosage to maintain the same pain-killing effect. Although the doctor knows that the morphine will eventually weaken the patient and thereby hasten death, administering the drug does reduce the pain and make the doomed patient's last moments more tolerable.¹⁸ According to strict legal interpretation, the doctor has knowingly "caused" the patient's death by hastening it. However, the primary purpose was to control the pain, and this was done in a legally and medically acceptable manner. Just as in each operation there is a balancing of risks, here the doctor must weigh the patient's increased comfort against the increased possi-

13. *Martin v. Commonwealth*, 184 Va. 1009, 37 S.E.2d 43 (1946).

14. *The Queen v. Dudley & Stevens*, 14 Q.B.D. 273, 15 Cox Crim. Cas. 624 (1884) (starving seamen in an open boat killed and consumed one of their own).

15. B. SHARTEL & M. PLANT, *supra* note 8, at 370.

16. Unreported 1950 New Hampshire decision, cited in N. Y. Times, March 10, 1950, §1, at 1, col. 6; B. SHARTEL & M. PLANT, *supra* note 8, at 370; Comment, *Criminal Law — Humanitarian Motive as a Defense to Homicide*, 48 MICH. L. REV. 1199 (1950).

17. 211 Mich. 187, 178 N.W. 690 (1920). See also FLA. STAT. §782.08 (1967). "Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter."

18. G. WILLIAMS, *supra* note 7, at 285-91.

bility of death. While control of the suffering is the primary effect of the treatment, the secondary effect may be the hastening of death.¹⁹ Although there are no cases on this point, it would seem that the doctor would be cleared of guilt because of the legitimate nature of the choice that he must make.²⁰ If, however, the doctor, in order to hasten death, had administered a dose far larger than needed to reduce the pain, he would be legally responsible.²¹

Part of the difficulty in this situation arises from a basic contradiction in the Hippocratic Oath.²² On entering the medical profession the doctor pledges to prolong and protect life and also to relieve the suffering of his patient. With the advance of modern medicine a patient who would have died in the past may today remain hanging to a thread of life. This places the doctor in a dilemma: keeping the patient "alive" may increase his suffering; yet, in using drugs to control the suffering, death may be brought closer. By choosing the former course, physicians support the criticism that they view death as an enemy that must be vanquished, and therefore go to heroic lengths to save all patients, regardless of the physical pain or emotional cost.²³

The previously discussed situations involve a physician committing an act that causes death; yet, it is also possible for death to occur if the doctor fails to act. Rather than prolong the existence of a patient in an irreversible coma, the doctor might stop all treatment and allow the patient to die mercifully and quickly. This would theoretically subject the doctor to criminal liability.²⁴ A statutory adoption of the death with dignity concept would grant a doctor in this situation legal immunity for ending supportive therapy if all the requirements of the statute had been met.

Liability for nonfeasance exists only where there is a legal duty to take positive action.²⁵ In *Regina v. Instan*,²⁶ failure to provide food or medical attention to a helpless aunt rendered her niece liable for the aunt's death. A duty to care for the aunt had arisen from the fact that the defendant and the aunt had lived together for some time. Similarly, the law imposes a duty upon a doctor to care for his patients. However, unlike the underlying rationale for the *Instan* duty, which arose from a factual setting,²⁷ the duty

19. *Id.* at 285-87.

20. Professor Williams prefers to justify the doctor's action by necessity rather than under some tenuous theory of causation. That is, the doctor necessarily had to administer the morphine to control the patient's suffering, instead of saying that death was actually caused by the original disease. *Id.* at 286-90.

21. *Id.* at 290.

22. J. FLETCHER, *MORALS AND MEDICINE* 172 (1954).

23. See generally B. GLAZER & M. STRAUSS, *AWARENESS OF DYING* 190-201 (1965).

24. A leading medical law scholar doubts that any criminal action would be concluded or even initiated based on mere inaction. B. SHARTEL & M. PLANT, *supra* note 8, at 371.

25. R. PERKINS, *CRIMINAL LAW* 592-93 (1969). The author distinguishes a forbearance or an intentional negative act from an unintentional omission.

26. 1 Q.B. 450, 17 Cox Crim. Cas. 602 (1893).

27. The exception to the rule of no liability for nonfeasance is that when a doctor

imposed upon a physician arises from a consensual relationship in which the patient seeks the assistance of the doctor, who agrees to aid him.²⁸ Having accepted the patient on a contractual basis, the physician must treat him until a cure is effected, the patient dies, or the doctor is dismissed from the case.²⁹ Although the doctor is given considerable latitude in the treatment he may prescribe, he is somewhat limited by the need for the patient's consent and prevailing medical opinion.³⁰ If the physician arbitrarily withdraws from the case without allowing reasonable time for the patient to obtain a substitute physician, he may be liable for any resulting injury.³¹ In *Blackburn's Administrator v. Curd*³² the defendant doctor had surgically removed a growth from the decedent's head. In spite of the requests of the relatives, the doctor refused to attend or treat his patient for three days following the operation. The doctor was held both civilly and criminally liable for the resulting death.

Related problems may occur where life-supporting systems or drugs have not yet been employed. If, for example, the drugs normally used to treat pneumonia have no effect, the doctor may still decide not to employ a somewhat experimental drug since the patient is in the terminal stages of leukemia. By not using this therapeutic measure, which has the prospect of prolonging life, the patient's death is hastened. From the physician's standpoint a decision not to use all available therapy is far easier to make than one that requires the withdrawal of a life-supporting system presently in use.³³ Assuming once again that both the patient and relatives prefer a gentle, merciful death, may the doctor be held criminally liable?

This final situation, where the doctor has not used all available means of treating a patient, appears to be a form of abandonment. Just as Dr. Curd was liable for refusing to treat Blackburn, so a doctor who fails to use all available drugs to treat pneumonia in a leukemia patient might be liable. The main difference in the two cases is one that the law refuses to recognize—the condition of the patient. In the *Curd* case the decedent was an able-bodied man who could expect complete recovery, while the hypothetical patient will die of leukemia in spite of all medical attention. Although the law declares that hastening the death of another is grounds for criminal liability, nonetheless the jury, in its role as the conscience of the community, has distinguished cases according to the condition of the patient.

or anyone else acts as a Good Samaritan he assumes a legal duty to carry on with his assistance until the danger point is past or until he is released. R. PERKINS, *supra* note 25, at 597.

28. Comment, *The Action of Abandonment in Medical Malpractice Litigation*, 36 TUL. L. REV. 834 (1962).

29. *Id.* at 835.

30. B. SHARTEL & M. PLANT, *supra* note 8, at 8.

31. Sanders & Dukeminier, *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation*, 15 U.C.L.A.L. REV. 357, 382 (1968).

32. 106 S.W. 1186 (Ky. Ct. App. 1908); *accord*, *Saunders v. Lischkoff*, 137 Fla. 826, 188 So. 815 (1939). *See also* Annot., 57 A.L.R.2d 432 (1958); Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999, 1005 (1967).

33. Elkinton, *The Dying Patient, the Doctor and the Law*, 13 VILL. L. REV. 740, 743 (1968).

In similar situations the punishment actually decreed has been far less than the legal maximum. Only once has a doctor been indicted in an American jurisdiction for killing a patient; and, in spite of rather clear evidence in that case, the jury acquitted the doctor when a causal relationship between his act and the death could not be proved.³⁴ After an exhaustive search, Professor Kamisar has concluded that there has never been a single indictment for mercy killing by omission.³⁵ Nonetheless, Kamisar suspects that medical personnel may allow some persons, particularly newborn defective infants, to die rather than attempting to prolong their existence.³⁶

In those cases involving a relative, an indictment frequently is not even sought,³⁷ perhaps because the elected prosecutor perceives a community sanction for some form of mercy killing. Moreover, when such cases are brought to trial the jury commonly convicts the defendant of a lesser crime.³⁸ Although the jury system is not consistent in exculpating accused mercy killers,³⁹ verdicts of not guilty are usually based upon failure to prove causation⁴⁰ and upon temporary insanity.⁴¹

The difficulties of proving such a charge against a physician and public opinion against such prosecutions may produce an outcome differing sharply from the letter of the law in cases involving euthanasia or mercy killing through nonfeasance.⁴² Although none of the cases cited parallel the situations in which the proposed statutory modification would take effect, they do reveal the necessity for having some definite basis upon which doctors may rely. In contrast to the broader scope of a euthanasia bill, the death with

34. *State v. Sander*, unreported 1950 New Hampshire decision, cited in *N.Y. Times*, March 10, 1950, §1, at 1, col. 6; Kamisar, *Some Non-religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 992 (1958). For facts, see text accompanying note 16 *supra*.

35. Kamisar, *supra* note 34, at 983 n.41.

36. See also G. WILLIAMS, *supra* note 7, at 32-33: "[T]he acephalous, ectocardiac, etc. monster will usually die quickly after birth. This beneficent tendency of nature is assisted, in Britain at any rate, by the practice of doctors and nurses, who, when an infant is born seriously malformed, do not strive officiously to keep it alive, even though they do nothing positive to kill it. The infant will be left unattended for a number of hours; a normal child will survive for quite a time without attention, but the monster usually dies."

37. Comment, *supra* note 16, at 1200.

38. *E.g.*, *Repouille v. United States*, 165 F.2d 152 (2d Cir. 1947) (defendant was convicted of second degree manslaughter with a recommendation of "utmost mercy." The judge sentenced him to five to ten years, and then immediately placed him on probation.)

39. See, *e.g.*, *State v. Mohr*, unreported 1950 Pennsylvania decision, cited in, *N.Y. Times*, April 4, 1950, §1, at 60, col. 4; *id.* April 8, 1950, §1, at 26, col. 1; *id.* April 11, 1950, §1, at 20, col. 5 (defendant was convicted of voluntary manslaughter and sentenced to three to six years for the mercy killing of his brother).

40. See, *e.g.*, *State v. Sander*, unreported 1950 New Hampshire decision, cited in, *N. Y. Times*, March 10 1950 §1 at 1 col. 6. For facts see text accompanying notes 16, 34 *supra*.

41. See, *e.g.*, *State v. Paight*, unreported 1950 Connecticut decision, cited in, *N. Y. Times*, Feb. 8, 1950, §1, at 1, col. 2 (a college girl killed her cancer ridden father); *State v. Braunsdorf*, unreported 1950 Michigan decision, cited in, *N.Y. Times*, May 23, 1950, §1, at 25, col. 4 (defendant had killed his crippled adult daughter).

42. G. WILLIAMS, *supra* note 7, at 292.

dignity proposal merely provides a framework within which a physician might legally discontinue treatment of a patient already beyond the point of meaningful life.

THE NEED FOR A STATUTE

One major criticism of the proposed statute is that it makes no change in the present criminal law. One physician has indicated that "the bill would be a meaningless addition which could lead to euthanasia."⁴³ However, the bill, if enacted, would provide the physician with legal assurance that does not currently exist. Several alternatives that would reach the same result without the necessity of a legislative enactment have been suggested.

Several legal scholars challenge the traditional view that an act of omission or forbearance in withholding life-preserving means may result in criminal liability for homicide.⁴⁴ Professor Williams, in what is otherwise a lucid plea for voluntary euthanasia, merely declares:⁴⁵

[M]ercy killing by omission to use medical means to prolong life is *probably lawful*. Although a physician is normally under a duty to use reasonable care to conserve his patient's life, he is *probably* exempted from that duty if life has become a burden to the patient.

In contrast, Professor Fletcher has developed an elaborate and persuasive argument based upon the distinction between *act* and *omission*.⁴⁶ He concedes that if stopping cardiac resuscitation or removing the needle used in intravenous therapy is considered an act, "then it is unequivocally forbidden: it is on a par with injecting air into the patient's veins."⁴⁷ However, he contends that if removing the needle is classified as an omission, then the nature of the relationship between the patient and his physician will determine whether such action is legally forbidden. Rejecting the usual physical movement test for determining what constitutes an act, Fletcher proposes instead that the test be: Did the activity *cause* harm or did it *permit* harm to occur? When a doctor turns off a respirator, which is a means of prolonging life, he does not cause death; rather he admits that the patient is beyond recovery and he permits death to occur. Thus, Fletcher would classify turning off the respirator or withdrawing the needle as an omission, not an act.

Fletcher disagrees with Williams' contention that killing by omission is probably lawful, and accepts the usual view that if a doctor has a duty to a

43. Orlando Sentinel, Feb. 20, 1969, §D at 6, col. 2.

44. See R. PERKINS, note 25 *supra* and accompanying text; Kamisar, *supra* note 35, at 983.

45. G. WILLIAMS, *supra* note 7, at 291 (emphasis added). Professor Williams cites neither case law nor statutory authority to support his belief.

46. Fletcher, note 32 *supra*. The same argument is found in Fletcher, *Legal Aspects of the Decision Not To Prolong Life*, 203 J.A.M.A. 65 (1968).

47. Fletcher, *supra* note 46, at 67.

patient, he is liable for omitting to perform that duty.⁴⁸ Therefore, the question must focus upon: What is the doctor's duty as determined by his relationship with the patient? If the patient requested that the doctor continue treating him, no matter how hopeless he was, and if the doctor accepted these conditions as part of the employment contract, the doctor's duty would then be to utilize all available resources to prolong life. If the doctor did less, such as omitting any treatment or terminating any life-supporting system, he would be responsible for failing to carry out his duty.⁴⁹ However, since patients seldom expressly make any such request,⁵⁰ what then is the duty of the doctor whose patient is in the terminal stages? Fletcher feels that the doctor should treat the patient according to the customary practices of the time and locale. In other words, if doctors customarily turn off respirators for doomed patients, and if this particular patient has not demanded anything more than the customary treatment, the doctor then may turn off the respirator and permit death to occur because the patient did not demand or expect any higher duty.⁵¹ In accord with this view is the basic rule that a doctor's discretion in treating patients is restricted by the standards of prevailing medical practice in the community.⁵² In sum, if a change occurs in the services and care that doctors usually perform, then the guidelines for determining what doctors are legally permitted to do will also change. For example, in the past it was beyond a doctor's legal and ethical discretion to use penicillin or an anaesthetic;⁵³ today, a doctor would be negligent for failing to use them when appropriate.

If a Florida court adopted Fletcher's approach, one of the bill's primary purposes would be accomplished since there would be no requirement to use extraordinary means to keep alive a person who had not so requested. Yet, unless this determination were combined with the safeguards of approval by relatives and concurrence by a panel of doctors, the decision could be made by a single doctor.

Existing constitutional law may provide another method of avoiding the need for the statutory proposal. Until 1965 the ninth amendment⁵⁴ was of negligible importance in constitutional interpretation. In *Griswold v. Connecticut*,⁵⁵ which invalidated a state birth control statute, Justice Goldberg's concurring opinion concluded that the historical purpose of the ninth amendment was to affirm that there are fundamental rights, in addition to those in the first eight amendments. Looking to the traditions and the col-

48. *Id.*

49. *Id.*

50. Although Fletcher does not specifically deal with the question, it seems apparent that under his interpretation the patient would be able to request in advance that the doctor turn off the machine and let him die when he was beyond hope, Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967).

51. Fletcher, *Legal Aspects of the Decision Not To Prolong Life*, 203 J.A.M.A. 65 (1968).

52. B. SHARTEL & M. PLANT, *supra* note 8, at 8.

53. Elkinton, *supra* note 33, at 743.

54. "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." U.S. CONST. amend. IX.

55. 381 U.S. 479 (1965).

lective conscience of the people, he found that the principle of marital privacy was so rooted in the people as to be fundamental and therefore protected. Although there is much historical debate, the prevailing view is that the ninth amendment was added to the Bill of Rights by James Madison to overcome the objection that the enumeration of certain rights would infer that no others existed.⁵⁶

Divergent views exist concerning what rights, if any, are encompassed by the ninth amendment. One scholar suggests that the rights of privacy, travel, political participation, access to information, freedom to engage in a business or profession, and treatment for mental illness are included; however, he also concludes that each of these can be connected in some way to a right contained in the first eight amendments.⁵⁷ In upholding a fair housing statute the Colorado supreme court found the ninth amendment sufficient authority for the legislature "to define and secure inherent reasonable expectations in life" by protecting fundamental rights.⁵⁸ However, such statutes can easily be connected to the right to acquire and possess property.⁵⁹ If the right to die with dignity is to be incorporated into the ninth amendment on a quasi-natural law basis, it appears mandatory that it be connected to an explicit right within the federal or state constitutions.⁶⁰

In *Skinner v. Oklahoma*⁶¹ the Supreme Court reversed an Oklahoma statute requiring sterilization for habitual criminals, without reaching the question of cruel and unusual punishment,⁶² on the ground that it failed to satisfy the requirements of the equal protection clause. Justice Douglas, writing for the Court, commented that an individual's fundamental civil right of procreation is included in due process.⁶³ If man has a right to reproduce, guaranteed by the ninth amendment and the due process clause, perhaps he has a similar natural right to die peacefully when he is on the verge of death.

In an area of medical law related to the proposed amendment, recent decisions have affirmed the right of an individual to refuse medical treat-

56. Dunbar, *James Madison and the Ninth Amendment*, 42 VA. L. REV. 626, 629 (1956). *Contra*, Franklin, *The Ninth Amendment as Civil Law Method and Its Implications for Republican Form of Government: Griswold v. Connecticut, South Carolina v. Katzenbach*, 40 TUL. L. REV. 487 (1966).

57. Kutner, *The Neglected Ninth Amendment: The "Other Rights" Retained by the People*, 51 MARQ. L. REV. 121, 135-42 (1967).

58. Colorado Anti-Discrimination Comm'n v. Case, 151 Colo. 235, 247, 380 P.2d 34, 41 (1962).

59. COLO. CONST. art. II, §3.

60. FLA. CONST. Decl. of Rights §1 contains similar wording: "The enunciation herein of certain rights shall not be construed to deny or impair others retained by the people." There are no cases interpreting this section.

61. 316 U.S. 535 (1942).

62. The death with dignity proposal cannot be connected to the cruel and unusual punishment clause, since the purpose of the eighth amendment is to prevent inhuman or tortuous punishment, not to regulate medical care in a hospital. *Black v. United States*, 269 F.2d 38, 43 (9th Cir. 1959).

63. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942).

ment for religious reasons, even if death is assured. The Illinois supreme court concluded that a lower court order which had authorized blood transfusions for a Jehovah's Witness violated the constitutional right of religious freedom.⁶⁴ Since no minor children were involved⁶⁵ and society was not faced with a clear and present danger,⁶⁶ no court could compel the individual to violate the tenets of her religion by accepting this treatment. In effect, she could will to die for religious reasons.⁶⁷ Since a person may cause his own death by refusing blood transfusions for religious reasons, the equal protection clause should logically guarantee the same option to all persons.

In a recent New York case,⁶⁸ the patient was voluntarily admitted to the hospital where, for personal, *nonreligious* reasons, he refused to allow blood transfusions as part of an operation. In spite of the county hospital's contention that the patient's refusal was the equivalent of suicide and hence forbidden by the penal law, the court concluded "it is the individual who is the subject of a medical decision who has the final say . . ."⁶⁹ and, since he was competent, he was entitled to refuse the transfusions. In a later case, the same court authorized an emergency operation because the patient was in a coma and unable either to give or deny permission for the operation.⁷⁰ Therefore, the New York position is that a person who is mentally competent may refuse to undergo medically necessary treatment on nonreligious grounds.

No reported Florida cases have dealt with this situation. If the Florida courts were to adopt the New York position, a patient would clearly have the right, initially limited to blood transfusions and operations, to make a competent decision as to the nature of the treatment and thus possibly as to the manner of his death. This position might naturally be expanded so that a patient would be enabled, for example, to refuse the assistance of an artificial respirator when he had no hope of recovery.⁷¹ This approach is limited

64. *In re Brooks' Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965). See generally Note, *The Right To Die*, 18 U. FLA. L. REV. 591 (1966).

65. *In re Brooks' Estate*, 32 Ill. 2d 361, 369, 205 N.E.2d 435, 440 (1965). Cf. *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964), *cert. denied*, 377 U.S. 985 (1964) (Douglas, J., dissenting), where blood transfusions were authorized in order to save the life of the unborn child of a Jehovah's Witness.

66. *In re Brooks' Estate*, 32 Ill. 2d 361, 368, 205 N.E.2d 435, 439 (1965). For examples of religious activities that do endanger society, see *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (objection to compulsory vaccination); *Reynolds v. United States*, 98 U.S. 145 (1878) (polygamy); *Harden v. State*, 188 Tenn. 17, 216 S.W.2d 708 (1949) (snake handling).

67. A controversial case reaching a contrary conclusion was *Application of the President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964). Judge J. Skelly Wright ordered blood transfusions to save the patient's life because the state had an interest in preserving the life of the mother of a seven-month old child. Judge Warren Burger strongly dissented, asserting that a hospital has no duty or moral obligation to preserve life at all costs. *Id.* at 1016.

68. *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1964).

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

70. *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964).

71. A thirty-three year old Detroit man, having relied on an artificial kidney for three years, finally decided to refuse further treatment. "I'm taking myself off the machine," he told the doctor. "I'm ready to die." The machine might have prolonged his life for

because it requires the patient to refuse further treatment *before* he becomes incompetent. Since many, if not most, patients never consider this possibility and reach no understanding with their physician regarding it, they would have no option but to continue in their vegetable-like existence. In contrast, the Florida proposal authorizes relatives to initiate proceedings when the patient is permanently incompetent.

Whether a patient is beyond hope of recovery is a medical determination; however, the broader question of when death has occurred cannot be so easily answered due to the vast gap that exists between the legal and medical definitions of death. Legal death occurs at the precise moment in time when respiration and the circulation of the blood permanently cease.⁷² In *Smith v. Smith*⁷³ the husband died immediately as the result of an accident, while the wife suffered permanent brain damage and never regained consciousness. On probate of the estate the court held that the wife's death occurred when her heart stopped beating seventeen days after the accident. The most ludicrous extension of this view was *Gray v. Sawyer*.⁷⁴ Following an accident in which a woman had been decapitated, her head was found lying ten feet from her body. She was actively bleeding "from near her neck and blood was gushing from her body in spurts."⁷⁵ The court held that she was then alive since the gushing of the blood was evidence that her heart was still beating.

In contrast, the medical view is that death is an ongoing process, not something that occurs at a moment in time.⁷⁶ Various spokesmen for the profession have proposed that the criterion for death be the cessation of activity of the central nervous system, that is, "the death of the brain," rather than the legal criteria of cessation of heartbeat and respiration.⁷⁷ After studying comatose individuals who had no discernible activity of the nervous system, a committee of the Harvard Medical School concluded that there are four characteristics of a *permanently* nonfunctioning brain: unresponsivity and unreceptivity, no spontaneous movements or breathing, no reflexes, and a flat or isoelectric electroencephalogram (EEG).⁷⁸ If, according

two months; "I could put up with the blindness and even the pain but the futility—I mean being inactive and with no chance to do anything—this is the worst of all." He signed a waiver removing himself from any additional treatment, and then the doctors used morphine to deaden the pain of his last days. St. Petersburg Times, Jan. 26, 1969, §A at 1, col. 3. See Sanders & Dukeminier, *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation*, 15 U.C.L.A.L. REV. 357, 381 (1968).

72. *Thomas v. Anderson*, 96 Cal. App. 2d 371, 215 P.2d 478 (4th Dist. Ct. App. 1950).

73. 229 Ark. 579, 317 S.W.2d 275 (1958).

74. 247 S.W.2d 496 (Ky. Ct. App. 1952).

75. *Id.* at 497.

76. Muller, *Legal Medicine and the Delimitation of Death*, 14 WORLD MEDICAL J. 140 (1967). *Contra*, Note, *Toward a Judicial Reform of Abortion*, 22 U. FLA. L. REV. 59, 64 (1969).

77. Muller, note 76 *supra*. See also Elkinton, *The Dying Patient, the Doctor and the Law*, 13 VILL. L. REV. 740, 745 (1968); Hamlin, *Life or Death by EEG*, 190 J.A.M.A. 112 (1964).

78. Ad Hoc Committee of Harvard Medical School, *A Definition of Irreversible Coma*,

to these four characteristics, the patient is hopelessly damaged, the doctor should declare death and turn off any life-supporting systems.⁷⁹ When permanent brain damage and irreversible coma have occurred, the patient is dead regardless of whether the heart is still beating. This proposed definition more adequately conforms to medical realities than does the legal definition. It is responsive to modern techniques that are able to restore "life" (according to the old definition based upon a heartbeat) and keep a person alive by artificial means even when his central nervous system is permanently destroyed.⁸⁰ If this proposed definition of death were to be accepted on such a wide scale that the legal profession were bound to accept it,⁸¹ the effect of the proposed statute would be partially accomplished. However, the new definition alone would not be helpful where patients without permanent and total brain damage, but nonetheless beyond hope of recovery, survive only through artificial means, such as a person on an artificial kidney.⁸²

Another method of preempting the need for a statute would be through a judicial extension of the post mortem arrangements of a dying person. In addition to property disposition, the current law allows one to make burial provisions⁸³ and to authorize organ transplants.⁸⁴ If one may make these arrangements, should he not also be able to make arrangements regarding the nature of his death by giving directions to his doctor?

Each of these five approaches, whether based on constitutional interpretation, medical definitions, or legal analysis, would allow some circumventing of the present law. A common objection is that each requires a gradual, yet substantial, modification of the law that will occur only on a case-by-case basis. Before a doctor acts he needs concrete assurance as to the legality of his action. However, none of these approaches provides the clear assurance afforded by the proposed statute.

THE ROLE OF PUBLIC OPINION

The author of the statutory proposal reports few unfavorable responses among the hundreds he has received.⁸⁵ The majority of responses are from those most likely to be immediately concerned — the aged. One elderly woman

205 J.A.M.A. 337 (1968). These criteria would apply to all patients except those with an overdose of sedatives; in those instances a flat EEG is not necessarily indicative of brain death.

79. *Id.* at 338.

80. Halley & Harvey, *Medical v. Legal Definitions of Death*, 204 J.A.M.A. 423, 425 (1968). See also Editorial, 204 J.A.M.A. 539 (1968). For the purpose of organ transplants an international symposium has recently adopted the definition of brain death. St. Petersburg Times, July 20, 1969, §A at 13, col. 1.

81. The law treats death as a factual question to be determined by doctors. Ad Hoc Committee, *supra* note 78, at 339.

82. See, e.g., *Smith v. Smith*, 229 Ark. 579, 317 S.W.2d 275 (1958).

83. *Kirksey v. Jernigan*, 45 So. 2d 188, 189 (Fla. 1950).

84. FLA. STAT. §§736.24-28 (1969). The Uniform Anatomical Gift Act does not define death, but merely states that one's organs may not be transplanted until a doctor has determined the time of death.

85. St. Petersburg Independent, Jan. 24, 1969, §A at 7, col. 1.

in good health wrote: "How much more joyous the next twenty years would be if I could at this time have a private, sensible arrangement with my doctor to let me die in peace and dignity instead of squandering my estate keeping alive a nothing."⁸⁶ Another woman, eighty years of age, wrote of her illness and then criticized her doctor: "[D]o I need to tell you life isn't much fun anymore? Yet when I said to my doctor (while in my right mind) that if I lost my mind or speech I wanted him to let me die with dignity—to refrain from doing anything to prolong my life, he acted as though he thought that was a ridiculous request."⁸⁷ Public opinion polls on related subjects tend to support the conclusion of a generally favorable response. Studies show that more than ninety per cent of the population wish to die quickly and avoid suffering.⁸⁸

Religious opinion seemingly favors the proposed statute. In a 1957 address Pope Pius XII declared that at the close of life physicians at the request of relatives might abandon all efforts to delay death in order to permit the patient, already virtually dead, to pass on in peace.⁸⁹ He also indicated that it was the function of the physician, not the Church, to determine when death had occurred. Pope Pius further declared that the moral obligation, which relatives owed to dying kin, extended only to ordinary or conventional, as contrasted with extraordinary, medical treatment:⁹⁰

[I]f artificial respiration or other advanced techniques in seemingly hopeless cases represent for the family such a burden as one could not in conscience impose upon them, they may lawfully ask the doctor to end his efforts and the doctor may lawfully comply.

He concluded that since artificial respiration and other advanced techniques go beyond generally accepted standards, it is not obligatory to use them in seemingly hopeless cases.⁹¹ Earlier the Pope had declared that one who is dying may use drugs to deaden the pain even if death is hastened.⁹² Similarly, the attitude of Jewish leaders is that any factor that artificially delays the patient's final demise may be withdrawn.⁹³ Although a major Florida newspaper supported the proposal editorially,⁹⁴ there was a lack of more general support from those in a position to influence public opinion. This was ap-

86. St. Petersburg Times, Feb. 24, 1969, §B at 6, col. 2.

87. St. Petersburg Times, Jan. 9, 1969, §B at 1, col. 1.

88. J. HINTON, DYING 23 (1929). See also G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 290 (1958). But cf., N. ST. JOHN-STEVAS, LIFE, DEATH AND THE LAW 266 (1961).

89. New York Times, Nov. 25, 1957, §1 at 1, col. 3.

90. *Id.*

91. *Id.* In discussing the death with dignity proposal a Catholic priest commented: "Living man has the right to life; dying man has the right to death." Orlando Sentinel, Feb. 20, 1969, §D at 6, col. 5.

92. New York Times, Feb. 19, 1957, §1 at 1, col. 5.

93. Whitlow & Rosner, *Extreme Measures To Prolong Life*, 202 J.A.M.A. 374, 376 (1967).

94. St. Petersburg Times, Feb. 24, 1969, §D at 2, col. 1.

parently due to a confusion with euthanasia, which prevented the prior constitutional proposal from reaching the floor of the Florida House in 1969.⁹⁵

DEATH WITH DIGNITY IN OTHER JURISDICTIONS

No American jurisdiction has adopted anything resembling the death with dignity proposal. While no other country has legalized voluntary euthanasia, some have made modifications of criminal liability, which are relevant to a discussion of death with dignity. For example, German law does not regard as homicide the "physician's failure to prolong artificially an expiring painful life by applying stimulants."⁹⁶ Switzerland permits a physician to make poison available to a fatally ill patient provided the doctor does not administer it himself.⁹⁷ Under the modern continental codes motive may be a mitigating element in the over-all guilt determination.⁹⁸ Several countries have introduced into their codes the separate crime of "homicide upon request," which carries a more lenient punishment than ordinary homicide.⁹⁹ Only in Uruguay does a compassionate homicide, performed on request of the victim, escape all punishment.¹⁰⁰ Sweden, and probably other code countries, allow "passive euthanasia" — that is, the withdrawal of life supporting therapy to allow a hopeless patient to die in peace.¹⁰¹

PROBABLE EFFECTS OF THE PROPOSAL

If the present proposal were enacted, the major result would be to grant doctors the legal assurance to permit an incurably ill patient to expire naturally. Criminal liability would be removed for acts performed pursuant to statutory safeguards requiring authorization by the next of kin. Second, many insurance policies make an exception when death is caused by an intentional, not accidental, taking of one's own life.¹⁰² Whether the courts would find that one who requested his doctor to let him die naturally, instead of keeping

95. St. Petersburg Times, July 3, 1969, §B at 2, col. 2. Aside from the inability to distinguish euthanasia from death with dignity, this attitude ignores the fact that many doctors admit to practicing "euthanasia" in the case of incurable adult sufferers. See Levisohn, *Voluntary Mercy Deaths*, 8 J. FOR. MEDICINE 57, 68 (1961).

96. Silving, *Euthanasia: A Study in Comparative Criminal Law*, 103 U. PA. L. REV. 350, 359 (1954), citing, SCHOENKE, STRAFGESETZBUCH, KOMMENTAR 565 (6th rev. ed. 1952).

97. SCHWEIZERISCHES STRAFGESETZBUCH 111-15 (1942), cited in, G. WILLIAMS, *supra* note 88, at 271, 297.

98. Silving, *supra* note 96, at 363.

99. *Id.* at 378. The additional element is that the victim was a fatally ill person who had specifically requested the accused to act.

100. PENAL CODE OF URUGUAY, art. 37 (1939), cited in, Silving, *supra* note 96, at 369.

101. Biörck, *On the Definition of Death*, 14 WORLD MEDICAL J. 137 (1967). With relatives' permission, a doctor disconnected the infusion drip of a hopelessly ill patient. The doctors were found not guilty, as the Swedish court concluded that no medical or human purpose would have been fulfilled by continuing the treatment, cited in, Biörck, *When Is Death?*, 1968 WIS. L. REV. 484, 488 (1968).

102. Gulf Life Ins. Co. v. Nash, 97 So. 2d 4 (Fla. 1957).

him alive artificially, legally committed suicide is an open question. Hopefully, enabling legislation would be enacted to prevent the loss of insurance proceeds or workmen's compensation benefits.¹⁰³

Potentially, the most important change, but the one most difficult to evaluate, would be the attitudes of the aged. As letters and opinion polls indicate,¹⁰⁴ the vast majority of people wish to die peacefully.¹⁰⁵ They view death not as an evil that must be resisted but as an inevitable end that comes to all men.¹⁰⁶ However, the nature of medical education causes doctors to oppose death.¹⁰⁷ Many doctors have a tendency to go "all out" to keep a patient alive regardless of the quality of the life.¹⁰⁸ In contrast, many nurses, who do not have ultimate responsibility, react towards hopeless patients by asking: "Why not let him die, instead of prolonging his life so he may suffer more?"¹⁰⁹ The new statute would give dying patients the foreknowledge and assurance that they need not continue to live in the twilight zone between life and death when all hope is gone, but that they could, *if they so desired*, come to a natural and peaceful end.

CONCLUSION

One doctor has noted: "There are too many instances . . . in which patients . . . are kept alive indefinitely by means of tubes inserted into their stomachs, or into their veins, or into their bladders, or into their rectums — and the whole sad scene thus created is encompassed within a cocoon of oxygen which is the next thing to a shroud."¹¹⁰ Since, of all the ages of man, death, involving only man and his Maker, is perhaps the most personal, it seems only reasonable to give man some voice in the manner of his death. While one individual may wish to be kept alive indefinitely with the aid of every technique at modern medicine's disposal, another may prefer to

103. *Whitehead v. Keene Roofing Co.*, 43 So. 2d 464 (Fla. 1949); FLA. STAT. §440.09 (3) (1967).

104. See notes 85-88 *supra*.

105. When patients are beyond hope of recovery they frequently beg and plead to be allowed to die. B. GLASER & M. STRAUSS, *AWARENESS OF DYING* 217 (1965). Those who are mentally alert occasionally try to trick nurses into increasing their drug dosage to hasten death. *Id.* at 211-12.

106. Wassermann, *Problematical Aspects of the Phenomenon of Death*, 14 *WORLD MEDICAL J.* 146 (1967). The deaths of Julius Caesar and Socrates are examples of this approach: "It seems to me most strange that men should fear, [s]eeing that death, a necessary end, [w]ill come when it will come." SHAKESPEARE, *JULIUS CAESAR*, II, ii, 35-37. "I do not think that I should gain anything by drinking the poison a little later; I should only be ridiculous in my own eyes for sparing and saving a life which is already forfeit. . . . A man should die in peace." PLATO, *PHAEDO*, 116a-118d.

107. Wasserman, note 106 *supra*.

108. B. GLASER & M. STRAUSS, *supra* note 105, at 185-86, 190, 192. For an almost bitter account of the manner in which the doctors kept her husband alive, see Anonymous, *A Way of Dying*, 199 *ATLANTIC*, Jan. 1957, at 53.

109. B. GLASER & M. STRAUSS, *supra* note 105, at 192, 217.

110. *Id.* at 201.

have life cease peacefully when death is certain. The former is assured of having his wish carried out, the latter is not.

While society does have an interest in the artificial prolongation of life,¹¹¹ most of the disadvantages fall on the patient and his relatives. Although there is the ever-present possibility of abuse,¹¹² it could be greatly reduced through proper procedures and safeguards. The law cannot lead science and medicine,¹¹³ but here a consensus of medicine, theology, and public opinion has been reached and the law is lagging behind. Although there are several ways that the law might deal with the problem,¹¹⁴ the most comprehensive and reassuring method of closing this gap would be to grant each citizen the right to be permitted to die with dignity. Recognizing that man wishes a voice in the quality of his life and the nature of his death, government should step back from the area and allow those who wish to avail themselves of the statute to die according to their own standards of dignity and peace.

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111. Potter, *The Paradoxical Preservation of a Principle*, 13 VILL. L. REV. 784 (1968).

112. See generally Kamisar, *Some Non-religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 975-99 (1958).

113. Burger, *The Law and Medical Advances*, 67 ANNALS, INTERNAL MEDICINE (Supp. 7, at 15 (1967)). See also *The New Biology and the Law* (remarks of Judge Warren E. Burger), 21 U. FLA. L. REV. 432 (1969).

114. In addition to those discussed in text accompanying notes 43-84 *supra*, see Potter, note 111 *supra*.