Foundations in the Law: Classic Cases in Medical Ethics

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NOTE ON CASES

This monograph has been prepared for use by ethicists, individuals in programs of clinical pastoral education, students of medical ethics, and others interested in the field. For that reason, case citations differ markedly from strict legal form; they are intended to be as user friendly as possible.

Complete citations, i.e., citations to multiple reporters are generally not given; the most commonly referenced reporter is typically the only one cited. With regard to state court decisions, if it is not obvious from which state a case came, the state is given by postal abbreviation in parenthesis with the date of the decision. Federal court decisions for the district, i.e., trial court, are identified by *F.Supp.* in the citation; decisions from the courts of appeal are identified by *F.* usually followed by a series number, i.e., *F.2d* or *F.3d*; and Supreme Court decisions are identified by *U.S.* No further distinctions, e.g., no location of the district court or number of the circuit for a court of appeals decision, are made. Citations to a particular page within a case are given only for quotations. Case citations within a decision have often been omitted, especially when they were duplicative; such omissions have not always been noted.

Ellipses marks indicate textual omissions from the original decisions. Minor corrections in grammar and syntax have occasionally been made when it was possible to do so without changing the writer's style; similarly, for clarity, numerals and section headings have occasionally been added and other minor stylistic changes have been made to achieve some parallelism. Most footnotes have been omitted; a few, of an explanatory nature have been added; all have been numbered so as to be consecutive. Occasionally an added, explanatory footnote is repeated in more than one case; this was done, so that individual cases could be copied and used without reference to the monograph as a whole. Only majority opinions are given.

Cases appear in alphabetical order in the Table of Contents. Appendix A lists cases chronologically; and Appendix B groups them by subject area. Appendix C is a table of cases listing all those cases in the Table of Contents and all cases cited within those primary cases.

FOREWORD

During the 2002 - 2003 academic year, Amy Burton, Tracy Allen, Vito Smyth, and I met for a semester in a special study called *Classic Cases in Medical Ethics*. I had previously queried a number of individuals working in the field of medical ethics about what legal cases they viewed as fundamental to the study of medical ethics. The four of us discussed their responses and formulated a list of *classic* cases. It is what you see here in the Table of Contents, except that to the responses I added (a) two cases having to do with the military, *Parker v. Levy* and *Feres v. United States*; and (b) the complaint in *Pollard*, the case regarding the Tuskegee Syphilis Study.

Each case was read in its entirety by each of us; then, one person prepared a shortened version, stressing ethics. We met as a group and discussed and, in the time honored fashion of lawyers and ethicists, often argued about that version: Did it add something new? Was it really a part of the foundation of ethical-legal jurisprudence? Did it include all that it should? Did it include any unnecessary material? Was there too much law and too little ethics?

Tracy Allen and Amy Burton spent numerous hours proofreading and editing the shortened cases. Vito Smyth and Martin Boyle, a medical malpractice attorney with the Department of Veterans Affairs and my husband, each spent many hours checking citations and trying to devise a system of citation that would be meaningful for non-lawyers. I again edited all the cases, developed the appendices, and formatted the document. Errors remain my responsibility.

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IN THE MATTER OF BABY K

United States District Court (E.D. Virginia, Alexandria Division), 1993
832 F. Supp. 1022

Opinion by Claude M. Hilton, J.

. . .

I. Findings of Fact

1. Plaintiff . . . is a general acute care hospital . . . that is licensed to provide diagnosis, treatment, and medical and nursing services to the public as provided by Virginia law. Among other facilities, the hospital has a pediatric intensive care department and an emergency department.

2. The hospital is a recipient of federal and state funds including those from Medicare and Medicaid and is a *participating hospital* pursuant to 42 U.S.C. §1395cc.

3. The hospital and its staff (including emergency doctors, pediatricians, neonatologists and pediatric intensivists) treat sick children on a daily basis.

4. Defendant Ms. H, a citizen of the Commonwealth of Virginia, is the biological mother of Baby K, an infant girl born by Caesarean-section at the hospital on October 13, 1992. Baby K was born with anencephaly.

5. Anencephaly is a congenital defect in which the brain stem is present but the cerebral cortex is rudimentary or absent. There is no treatment that will cure, correct, or ameliorate anencephaly. Baby K is permanently unconscious and cannot hear or see. Lacking a cerebral function, Baby K does not feel pain. Baby K has brain stem functions primarily limited to reflexive actions such as feeding reflexes (rooting, sucking, swallowing), respiratory reflexes (breathing, coughing), and reflexive responses to sound or touch. Baby K has a normal heart rate, blood pressure, liver function, digestion, kidney function, and bladder function and has gained weight since her birth. Most anencephalic infants die within days of birth.

6. Baby K was diagnosed prenatally as being anencephalic. Despite the counseling of her obstetrician and neonatologist that she terminate her pregnancy, Ms. H refused to have her unborn child aborted.

7. A Virginia court of competent jurisdiction has found defendant Mr. K, a citizen of the Commonwealth of Virginia, to be Baby K's biological father.

8. Ms. H and Mr. K have never been married.

9. Since Baby K's birth, Mr. K has, at most, been only distantly involved in matters relating to the infant. Neither the hospital nor Ms. H ever sought Mr. K's opinion or consent in providing medical treatment to Baby K.

10. Because Baby K had difficulty breathing immediately upon birth, hospital physicians provided her with mechanical ventilator treatment to allow her to breathe.

11. Within days of Baby K's birth, hospital medical personnel urged Ms. H to permit a do-not-resuscitate order for Baby K that would discontinue ventilator treatment. Her physicians told her that no treatment existed for Baby K's anencephalic condition, no therapeutic or palliative purpose was served by the treatment, and that ventilator care was medically unnecessary and inappropriate. Despite this pressure, Ms. H continued to request ventilator treatment for her child.

12. Because of Ms. H's continued insistence that Baby K receive ventilator treatment, her treating physicians requested the assistance of the hospital's ethics committee in overriding the mother's wishes.

13. A three person [subcommittee of the] ethics committee, [the subcommittee being] composed of a family practitioner, a psychiatrist and a minister, met with physicians providing care to Baby K. On October 22, 1992, the group concluded that Baby K's ventilator treatment should end because "such care is futile" and decided to "wait a reasonable time for the family to help the caregiver terminate aggressive therapy." If the family refused to follow this advice, the committee recommended that the hospital should "attempt to resolve this through our legal system."

14. Ms. H subsequently rejected the committee's recommendation. Before pursuing legal action to override Ms. H's position, the hospital decided to transfer the infant to another healthcare facility.

15. Baby K was transferred to a nursing home . . . in Virginia on November 30, 1992 during a period when she was not experiencing respiratory distress and, thus, did not need ventilator treatment. A condition of the transfer was that the hospital agreed to take the infant back for ventilator treatment which was unavailable at the nursing home, if [she] again developed respiratory distress. Ms. H agreed to this transfer.

16. Baby K returned to the hospital on January 15, 1993 to receive ventilator treatment after experiencing respiratory distress. Hospital officials again attempted to persuade Ms. H to discontinue ventilator treatment for her child. Ms. H again refused. After Baby K could breathe on her own, she was transferred back to the nursing home on February 12, 1993.

17. Baby K again experienced breathing difficulties on March 3, 1993 and returned to the hospital to receive ventilator treatment.

18. On March 15, 1993, Baby K received a tracheotomy, a procedure in which a breathing tube was surgically implanted in her windpipe, to facilitate ventilator treatment. Ms. H agreed to this operation.

19. After no longer requiring ventilator treatment, Baby K was transferred back to the nursing home on April 13, 1993 where she continues to live.

20. Baby K will almost certainly continue to have episodes of respiratory distress in the future. In the absence of ventilator treatment during these episodes, she would suffer serious impairment of her bodily functions and soon die.

21. Ms. H visits Baby K daily. The mother opposes the discontinuation of ventilator treatment when Baby K experiences respiratory distress because she believes that all human life has value, including her anencephalic daughter's life. Ms. H has a firm Christian faith that all life should be protected. She believes that God will work a miracle if that is his will. Otherwise, Ms. H believes, God, and not other humans, should decide the moment of her daughter's death. . . .

22. On the hospital's motion, a guardian *ad litem* was appointed to represent Baby K pursuant to Virginia Code §8.01-9.

23. Both the guardian *ad litem* and Mr. K share the hospital's position that ventilator treatment should be withheld from Baby K when she experiences respiratory distress.

24. The hospital has stipulated that it is not proposing to deny ventilator treatment to Baby K because of any lack of adequate resources or any inability of Ms. H to pay for the treatment.

II. Conclusions of Law

Pursuant to the Declaratory Judgment Act, 28 U.S.C. §2201, the hospital has sought declaratory and injunctive relief. . . . [The three relevant federal statutes are discussed hereunder.]

A. Emergency Medical Treatment and Active Labor Act – 41 U.S.C. §1395dd

Plaintiff seeks a declaration that its refusal to provide Baby K with life-supporting medical care would not transgress the Emergency Medical Treatment and Active Labor Act (EMTALA), . . . [which] requires that participating hospitals provide stabilizing medical treatment to any person who comes to an emergency department in an emergency medical condition when treatment is requested on that person's behalf. An *emergency medical condition* is defined in the statute as "acute symptoms of sufficient severity . . . such that the absence of immediate medical attention could reasonably be expected to result in . . . serious impairment to bodily functions, or

serious dysfunction of any bodily organ or part." *Stabilizing* medical treatment is defined as "such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition" will result. . . .

The hospital admits that Baby K would meet these criteria if she is brought to the hospital while experiencing breathing difficulty. As stated in the hospital's complaint, when Baby K is in respiratory distress, that condition is "such that the absence of immediate medical attention could reasonably be expected to cause serious impairment to her bodily functions" -- i.e., her breathing difficulties constitute an emergency medical condition. The hospital also concedes in its complaint that ventilator treatment is required in such circumstances to assure "that no material deterioration of Baby K's condition is likely to occur" -- i.e., a ventilator is necessary to *stabilize* the baby's condition. These admissions establish that the hospital would be liable under EMTALA if Baby K arrived there in respiratory distress (or some other emergency medical condition) and the hospital failed to provide mechanical ventilation (or some other medical treatment) necessary to stabilize her acute condition.

. . .

Despite EMTALA's clear requirements and in the face of the hospital's admissions, the hospital seeks an exemption from the statute for instances in which the treatment at issue is deemed *futile* or *inhumane* by the hospital physicians. The plain language of the statute requires stabilization of an emergency medical condition. The statute does not admit of any futility or inhumanity exceptions. Any argument to the contrary should be directed to the U.S. Congress, not to the federal judiciary.

. . .

B. Rehabilitation Act of 1973 – [Public Law 93-112]

Section 504 of the Rehabilitation Act prohibits discrimination against *an otherwise qualified* handicapped individual, solely by reason of his or her handicap, under any program or activity receiving federal financial assistance, [e.g. Medicare or Medicaid]. Baby K is a *handicapped* and *disabled* person within the meaning of the Rehabilitation Act of 1973. --A *handicapped individual* under the Rehabilitation Act "includes an infant who is born with a congenital defect." *Bowen v. American Hospital Association,* 476 U.S. 610 (1986).

Section 504's plain text spells out the necessary scope of inquiry: Is Baby K otherwise qualified to receive ventilator treatment, and is ventilator treatment being threatened with being denied because of an unjustified consideration of her anencephalic handicap? The hospital has admitted that the sole reason it wishes to withhold ventilator treatment for Baby K, over her mother's objections, is because of Baby K's anencephaly -- her handicap and disability.

. . .

When the Rehabilitation Act was passed in 1973, Congress intended that discrimination on the basis of a handicap be treated in the same manner that Title VI of the Civil Rights Act treats racial discrimination. This . . . shatters the hospital's contention that ventilator treatment should be withheld because Baby K's recurring breathing troubles are intrinsically related to her handicap. No such distinction would be permissible within the context of racial discrimination. . . . [T]he hospital's desire to withhold ventilator treatment from Baby K over her mother's objections would violate the Rehabilitation Act.

C. Americans with Disabilities Act of 1990 – Public Law 101-336

Section 302 of the Americans with Disabilities Act (ADA) prohibits discrimination against disabled individuals by *public accommodations*. A *disability* is "a physical or mental impairment that substantially limits one or more of the major life activities" of an individual. This includes any physiological disorder or condition affecting the neurological system, musculoskeletal system, or sense organs, among others. Anencephaly is a disability, because it affects the baby's neurological functioning, ability to walk, and ability to see or talk. *Public accommodation* is defined to include a . . . hospital. . . .

Section 302(a) of the ADA states a general rule of nondiscrimination against the disabled:

> General rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodation of any place of public accommodations by any person who owns, leases (or leases to), or operates a place of public accommodation.
>
> . . .

The hospital asks this court for authorization to deny the benefits of ventilator services to Baby K by reason of her anencephaly. The hospital's claim is that it is futile to keep alive an anencephalic baby, even though the mother has requested such treatment. But the plain language of the ADA does not permit the denial of ventilator services that would keep alive an anencephalic baby when those life-saving services would otherwise be provided to a baby without disabilities at the parent's request. . . .

. . .

F. Constitutional and Common Law Issues

Baby K's parents disagree over whether or not to continue medical treatment for her. Mr. K and Baby K's guardian *ad litem* join the hospital in seeking the right to override the wishes of Ms. H, Baby K's mother. . . . A parent has a constitutionally protected right to bring up children [which is] grounded in the Fourteenth Amendment's due process clause. *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters,* 268 U.S. 510 (1925). Parents have the primary role in the nurture and upbringing of their children. *Wisconsin v. Yoder,* 406 U.S. 205 (1972); *Prince v. Massachusetts,* 321 U.S. 158 (1944)[1]. Decisions for children can be based in the parent's free exercise of religion, protected by the First Amendment. *Pierce, supra,* and *Yoder, supra.*

These constitutional principles extend to the right of parents to make medical treatment decisions for their minor children. Absent a finding of neglect or abuse, parents retain plenary authority to seek medical care for their children, even when the decision might impinge on a liberty interest of the child. *Parham v. J.R.,* 442 U.S. 584 (1979) -- commitment of child to mental health hospital. Indeed, there is a "presumption that the parents act in the best interests of their child" because the "natural bonds of affection lead parents to act in the best interests of their children." *Id.* at 602. State law rights to make medical and surgical treatment decisions for a minor child are grounded in the common law and can also be inferred from state statutes. . . .

Based on Ms. H's natural bonds of affection, and the relative noninvolvement of Baby K's biological father, the constitutional and common law presumption must be that Ms. H. is the appropriate decision-maker. "When parents do not agree on the issue of termination of life support . . . this court must yield to the presumption in favor of life." *In re Jane Doe, A Minor,* Civ. No. D-93064, memorandum opinion at 18 (Super. Ct. Fulton Co., Ga., October 17, 1991), aff'd., 418 S.E.2d 3 (GA, 1992). This presumption arises from the explicit guarantees of a right to life in the United States Constitution, Amendments V and XIV, and the Virginia Constitution, Article 1, Sections 1 and 11.

The presumption in favor of life in this case is also based on Ms. H's religious conviction that all life is sacred and must be protected, thus implicating her First Amendment rights. When an individual asserts "the Free Exercise Clause in conjunction with other constitutional protections, such as . . . the right of parents," only a clear and compelling governmental interest can justify a statute that interferes with the

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[1] Added. This case is often quoted in the context of medical ethics for the famous phrase it contains -- "Parents may be free to become martyrs themselves. But it does not follow [that] they are free to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." *Prince, supra,* at 171. However, this case is not about medical care. While it does deal with parents who are Jehovah's Witnesses, it is not about denial of medical care as many people think; rather, it raised the question of whether allowing a child to sell *Watchtower* and *Consolation*, Jehovah's Witness publications, is a violation of the child labor laws of the Commonwealth of Massachusetts.

person's religious convictions. *Employment Div., Department of Human Resources of Oregon v. Smith,* 494 U.S. 872 (1990); and *Yoder, supra.*

The hospital cannot establish any *clear and compelling* interest in this case. The Supreme Court has not decided whether the right to liberty encompasses a right to refuse medical treatment, often called a right to die.[2] Parents have standing to assert the constitutional rights of their minor children. *Eisenstadt v. Baird,* 405 U.S. 438 (1972).

. . .

Reflecting the constitutional principles of family autonomy and the presumption in favor of life, courts have generally scrutinized a family's decision only where the family has sought to terminate or withhold medical treatment for an incompetent minor or incompetent adult. In a recent case in which a hospital sought to terminate life-supporting ventilation over the objections of the patient's husband, a Minnesota state court refused to remove decision-making authority from the husband. *In re Wanglie,* No. PX-91-283 (Prob. Ct., Hennepin Co., MN., June 28, 1991). Likewise, where parents disagreed over whether to continue life-supporting mechanical ventilation, nutrition, and hydration for a minor child in an irreversible stupor or coma, a Georgia state court gave effect to the decision of the parent opting in favor of life support. *In re Jane Doe, supra.*

At the very least, the hospital must establish by clear and convincing evidence that Ms. H's treatment decision should not be respected because it would constitute abuse or neglect of Baby K. This clear and convincing evidence standard has been adopted by numerous courts and was upheld by the Supreme Court in *Cruzan* in authorizing the withdrawal of life-supporting treatment from an incompetent patient. In this case, where the choice essentially devolves to a subjective determination as to the quality of Baby's K's life, it cannot be said that the continuation of Baby K's life is so unreasonably harmful as to constitute child abuse or neglect.

For the foregoing reasons, the hospital's request for a declaratory judgment that the withholding of ventilator treatment from Baby K would not violate the EMTALA, the Rehabilitation Act of 1973, the ADA, the Child Abuse Amendments of 1984, and the Virginia Medical Malpractice Act should be denied. Under the EMTALA, the Rehabilitation Act of 1973, and the ADA, the hospital is legally obligated to provide ventilator treatment to Baby K. The court makes no ruling as to any rights or obligations under the Child Abuse Amendments of 1984 or under the Virginia Medical Malpractice Act.

An appropriate order shall issue.

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[2] Added. See *Washington v. Glucksburg,* 521 U.S. 702 (1997) and *Vacco v. Quill,* 521 U.S. 793 (1997), *infra.*

IN THE MATTER OF BABY M

Supreme Court of New Jersey, 1987
109 N.J. 396; 537 A.2d 1227

Opinion by Wilentz, J.

In this matter the court is asked to determine the validity of a contract that purports to provide a new way of bringing children into a family. For a fee of $10,000, a woman agrees to be artificially inseminated with the semen of another woman's husband: she is to conceive a child; carry it to term; and, after its birth, surrender it to the natural father and his wife. The intent of the contract is that the child's natural mother will thereafter be forever separated from her child. The wife is to adopt the child, and she and the natural father are to be regarded as its parents for all purposes. The contract providing for this is called a *surrogacy contract*, the natural mother [is] inappropriately called the *surrogate mother*.

. . .

I. Facts

In February 1985, William Stern and Mary Beth Whitehead entered into a surrogacy contract. It recited that Stern's wife, Elizabeth, was infertile, that they wanted a child, and that Mrs. Whitehead was willing to provide that child as the mother with Mr. Stern as the father.

The contract provided that through artificial insemination using Mr. Stern's sperm, Mrs. Whitehead would become pregnant; carry the child to term; bear it; deliver it to the Sterns; and, thereafter, do whatever was necessary to terminate her maternal rights, so that Mrs. Stern could thereafter adopt the child. Mrs. Whitehead's husband, Richard, was also a party to the contract; Mrs. Stern was not. . . . Although Mrs. Stern was not a party to the surrogacy agreement, [presumably to avoid the application of the baby-selling statute to this arrangement,] the contract gave her sole custody of the child in the event of Mr. Stern's death. . . .

Mr. Stern, for his part, agreed to attempt the artificial insemination and to pay Mrs. Whitehead $10,000 after the child's birth, on its delivery to him. In a separate contract, Mr. Stern agreed to pay $7,500 to the Infertility Center of New York (hereinafter Infertility Center or Center). The Center's advertising campaigns solicit surrogate mothers and encourage infertile couples to consider surrogacy. [It] . . . arranged for the surrogacy contract by bringing the parties together, explaining the process to them, furnishing the contractual form, and providing legal counsel.

The history of the parties' involvement in this arrangement suggests their good faith. William and Elizabeth Stern were married in July 1974, having met at the University of Michigan, where both were Ph.D. candidates. Due to financial considerations and Mrs. Stern's pursuit of a medical degree and residency, they decided to defer starting a family until 1981. Before then, however, Mrs. Stern learned that she might have multiple sclerosis and that the disease in some cases renders pregnancy a serious health risk. Her anxiety appears to have exceeded the actual risk . . . [but] . . . that anxiety was evidently quite real. . . . Based on the perceived risk, the Sterns decided to forego having their own children. The decision had special significance for Mr. Stern. Most of his family had been destroyed in the Holocaust. As the family's only survivor, he very much wanted to continue his bloodline.

Initially the Sterns considered adoption but were discouraged by the substantial delay apparently involved and by the potential problem they saw arising from their age and their differing religious backgrounds. They were most eager for some other means to start a family.

The paths of Mrs. Whitehead and the Sterns to surrogacy were similar. Both responded to advertising by the Infertility Center. . . . Mrs. Whitehead's response apparently resulted from her sympathy with family members and others who could have no children (she stated that she wanted to give another couple the *gift of life*); she also wanted the $10,000 to help her family.

Both parties, undoubtedly because of their own self-interest, were less sensitive to the implications of the transaction than they might otherwise have been. Mrs. Whitehead, for instance, appears not to have been concerned about whether the Sterns would make good parents for her child; the Sterns, on their part, while conscious of the obvious possibility that surrendering the child might cause grief to Mrs. Whitehead, overcame their qualms because of their desire for a child. At any rate, both the Sterns and Mrs. Whitehead were committed to the arrangement; both thought it right and constructive.

. . . On February 6, 1985, Mr. Stern and Mr. and Mrs. Whitehead executed the surrogate parenting agreement. After several artificial inseminations over a period of months, Mrs. Whitehead became pregnant. The pregnancy was uneventful and on March 27, 1986, Baby M was born.

. . .

Mrs. Whitehead realized, almost from the moment of birth, that she could not part with this child. She had felt a bond with it even during pregnancy. Some indication of the attachment was conveyed to the Sterns at the hospital when they told Mrs. Whitehead what they were going to name the baby. She apparently broke into tears and indicated that she did not know if she could give up the child. She talked about how the

baby looked like her other daughter, and [she] made it clear that she was experiencing great difficulty with the decision.

Nonetheless, Mrs. Whitehead was, for the moment, true to her word. Despite powerful inclinations to the contrary, she turned her child over to the Sterns on March 30 at the Whiteheads' home.

The Sterns were thrilled with their new child. . . . [They] looked forward to raising their daughter, whom they named Melissa. While aware by then that Mrs. Whitehead was undergoing an emotional crisis, they were as yet not cognizant of the depth of that crisis. . . .

Later in the evening of March 30, Mrs. Whitehead became deeply disturbed, disconsolate, [and] stricken with unbearable sadness. She had to have her child. She could not eat, sleep, or concentrate on anything other than her need for her baby. The next day she went to the Sterns' home and told them how much she was suffering.

The depth of Mrs. Whitehead's despair surprised and frightened the Sterns. She told them that she could not live without her baby, that she must have her, even if only for one week, [and] that thereafter she would surrender her child. The Sterns, concerned that Mrs. Whitehead might indeed commit suicide, not wanting under any circumstances to risk that, and, in any event, believing that Mrs. Whitehead would keep her word, turned the child over to her. . . . The struggle over Baby M began when it became apparent that Mrs. Whitehead could not return the child to Mr. Stern. Due to Mrs. Whitehead's refusal to relinquish the baby, Mr. Stern filed a complaint seeking enforcement of the surrogacy contract. He alleged, accurately, that Mrs. Whitehead had not only refused to comply with the surrogacy contract but had threatened to flee from New Jersey with the child in order to avoid even the possibility of his obtaining custody. . . . And that is precisely what she did. . . .

The Whiteheads immediately fled to Florida with Baby M. They stayed initially with Mrs. Whitehead's parents, where one of Mrs. Whitehead's children had been living. For the next three months, the Whiteheads and Melissa lived at roughly 20 different hotels, motels, and homes in order to avoid apprehension. From time to time Mrs. Whitehead would call Mr. Stern to discuss the matter; the conversations, recorded by Mr. Stern on advice of counsel, show an escalating dispute about rights, morality, and power, accompanied by threats of Mrs. Whitehead to kill herself, [and] to kill the child. . . .

Eventually the Sterns discovered where the Whiteheads were staying, commenced supplementary proceedings in Florida, and obtained an order requiring the Whiteheads to turn over the child. Police in Florida enforced the order, forcibly removing the child from her grandparents' home. She was soon thereafter brought to New Jersey and turned over to the Sterns. . . . Mrs. Whitehead was awarded limited visitation with Baby M.

The Sterns' complaint, in addition to seeking possession and, ultimately, custody of the child, sought enforcement of the surrogacy contract. Pursuant to the contract, it asked that the child be permanently placed in their custody, that Mrs. Whitehead's parental rights be terminated, and that Mrs. Stern be allowed to adopt the child, i.e., that, for all purposes, Melissa would become the Sterns' child.

The trial took 32 days over a period of more than two months. . . . [T]he trial court announced its opinion from the bench. It held that the surrogacy contract was valid; ordered that Mrs. Whitehead's parental rights be terminated and that sole custody of the child be granted to Mr. Stern; and, after hearing brief testimony from Mrs. Stern, immediately entered an order allowing the adoption of Melissa by Mrs. Stern, all in accordance with the surrogacy contract. Pending the outcome of the appeal, we granted a continuation of visitation to Mrs. Whitehead, although slightly more limited than the visitation allowed during the trial.

. . .

Mrs. Whitehead appealed. This court granted direct certification. . . .

Mrs. Whitehead contends that the surrogacy contract, for a variety of reasons, is invalid. She contends that it conflicts with public policy since it guarantees that the child will not have the nurturing of both natural parents -- presumably New Jersey's goal for families. She further argues that it deprives the mother of her constitutional right to the companionship of her child, and that it conflicts with statutes concerning termination of parental rights and adoption. . . .

. . .

The Sterns claim that the surrogacy contract is valid and should be enforced, largely for the reasons given by the trial court. They claim a constitutional right of privacy, which includes the right of procreation, and the right of consenting adults to deal with matters of reproduction as they see fit. As for the child's best interests, their position is factual: given all of the circumstances, the child is better off in their custody with no residual parental rights reserved for Mrs. Whitehead.

Of considerable interest in this clash of views is the position of the child's guardian *ad litem*, wisely appointed by the court at the outset of the litigation. As the child's representative, her role in the litigation, as she viewed it, was solely to protect the child's best interests. She therefore took no position on the validity of the surrogacy contract and, instead, devoted her energies to obtaining expert testimony uninfluenced by any interest other than the child's. . . . She first took the position, based on her experts' testimony, that the Sterns should have primary custody and that, while Mrs. Whitehead's parental rights should not be terminated, no visitation should be allowed for five years. As a result of subsequent developments, mentioned *infra*, her view has

changed. She now recommends that no visitation be allowed at least until Baby M reaches maturity.

II. Invalidity and Unenforceability of Surrogacy Contract

We have concluded that this surrogacy contract is invalid. Our conclusion has two bases: direct conflict with existing statutes and conflict with the public policies of this state, as expressed in its statutory and decisional law.

One of the surrogacy contract's basic purposes, to achieve the adoption of a child through private placement, [al]though permitted in New Jersey "is very much disfavored." *Sees v. Baber,* 74 N.J. 201 (1977). Its use of money for this purpose -- and we have no doubt whatsoever that the money is being paid to obtain an adoption and not, as the Sterns argue, for the personal services of Mary Beth Whitehead -- is illegal and perhaps criminal. New Jersey Statutes Annotated (N.J.S.A.) 9:3-54. In addition to the inducement of money, there is the coercion of contract: the natural mother's irrevocable agreement, prior to birth, even prior to conception, to surrender the child to the adoptive couple. Such an agreement is totally unenforceable in private placement adoption. Even where the adoption is through an approved agency, the formal agreement to surrender occurs only *after* birth (as we read N.J.S.A. 9:2-16 and -17, and similar statutes), and then, by regulation, only after the birth mother has been offered counseling. N.J.S.A. 10:121A-5.4(c). . . .

The foregoing provisions not only directly conflict with New Jersey statutes, but also offend long-established state policies. These critical terms, which are at the heart of the contract, are invalid and unenforceable; the conclusion therefore follows, without more, that the entire contract is unenforceable.

A. Conflict with Statutory Provisions

The surrogacy contract conflicts with 1) laws prohibiting the use of money in connection with adoptions;[3] 2) laws requiring proof of parental unfitness or

[3] N.J.S.A. 9:3-54 reads as follows:

> a. No person, firm, partnership, corporation, association, or agency shall make, offer to make or assist or participate in any placement for adoption and in connection therewith
>
> (1) Pay, give or agree to give any money or any valuable consideration, or assume or discharge any financial obligation; or
>
> (2) Take, receive, accept or agree to accept any money or any valuable consideration.
>
> b. The prohibition of subsection *a* shall not apply to the fees or services of any approved agency in connection with a placement for adoption, nor shall such prohibition apply to the payment or reimbursement of medical, hospital or other similar expenses incurred in connection with the birth or any illness of the child, or to the acceptance of such reimbursement by a parent of the child.
>
> c. Any person, firm, partnership, corporation, association or agency violating this section shall be guilty of a high misdemeanor.

abandonment before termination of parental rights is ordered or an adoption is granted; and 3) laws that make surrender of custody and consent to adoption revocable in private placement adoptions.

. . .

. . . The payment of the $10,000 occurs only on surrender of custody of the child and "completion of the duties and obligations" of Mrs. Whitehead, including termination of her parental rights to facilitate adoption by Mrs. Stern. As for the contention that the Sterns are paying only for services and not for an adoption, we need note only that they would pay nothing in the event the child died before the fourth month of pregnancy, and only $1,000 if the child were stillborn, even though the "services" had been fully rendered. Additionally, one of Mrs. Whitehead's estimated costs, to be assumed by Mr. Stern, was an *Adoption Fee,* presumably for Mrs. Whitehead's incidental costs in connection with the adoption.

Mr. Stern knew he was paying for the adoption of a child; Mrs. Whitehead knew she was accepting money so that a child might be adopted; the Infertility Center knew that it was being paid for assisting in the adoption of a child. The actions of all three worked to frustrate the goals of the statute. It strains credulity to claim that these arrangements, touted by those in the surrogacy business as an attractive alternative to the usual route leading to an adoption, really amount to something other than a private placement adoption for money.

The prohibition of our statute is strong. Violation constitutes a high misdemeanor, N.J.S.A. 9:3-54c, a third-degree crime, N.J.S.A. 2C:43-1b, carrying a penalty of three to five years imprisonment. N.J.S.A. 2C:43-6a(3). The evils inherent in baby-bartering are loathsome for a myriad of reasons. The child is sold without regard for whether the purchasers will be suitable parents. N. Baker, *Baby Selling: The Scandal of Black Market Adoption* (1978). The natural mother does not receive the benefit of counseling and guidance to assist her in making a decision that may affect her for a lifetime. In fact, the monetary incentive to sell her child may, depending on her financial circumstances, make her decision less voluntary. Furthermore, the adoptive parents may not be fully informed of the natural parents' medical history.

. . .

The termination of Mrs. Whitehead's parental rights, called for by the surrogacy contract and actually ordered by the court, fails to comply with the stringent requirements of New Jersey law. . . .

. . .

. . . [I]t is clear that a contractual agreement to abandon one's parental rights, or not to contest a termination action, will not be enforced in our courts. The legislature

would not have so carefully, so consistently, and so substantially restricted termination of parental rights if it had intended to allow termination to be achieved by one short sentence in a contract.

Since the termination was invalid, it follows, as noted above, that adoption of Melissa by Mrs. Stern could not properly be granted.

The provision in the surrogacy contract stating that Mary Beth Whitehead agrees to "surrender custody . . . and terminate all parental rights" contains no clause giving her a right to rescind. It is intended to be an irrevocable consent to surrender the child for adoption -- in other words, an irrevocable commitment by Mrs. Whitehead to turn Baby M over to the Sterns and thereafter to allow termination of her parental rights. . . .

. . . [A provision such as was in the contract,] making irrevocable the natural mother's consent to surrender custody of her child in a private placement adoption, clearly conflicts with New Jersey law.

. . .

Contractual surrender of parental rights is not provided for in our statutes as now written. . . . There is no doubt that a contractual provision purporting to constitute an irrevocable agreement to surrender custody of a child for adoption is invalid.

. . .

B. Public Policy Considerations

The surrogacy contract's invalidity . . . is further underlined when its goals and means are measured against New Jersey's public policy. The contract's basic premise, that the natural parents can decide in advance of birth which one is to have custody of the child, bears no relationship to the settled law that the child's best interests shall determine custody. . . .

The surrogacy contract guarantees permanent separation of the child from one of its natural parents. Our policy, however, has long been that, to the extent possible, children should remain with, and be brought up by, both of their natural parents. . . .

The surrogacy contract violates the policy of this state that the rights of natural parents are equal concerning their child, the father's right no greater than the mother's. "The parent and child relationship extends equally to every child and to every parent, regardless of the marital status of the parents." N.J.S.A. 9:17-40. . . .

. . .

Under the contract, the natural mother is irrevocably committed before she knows the strength of her bond with her child. She never makes a totally voluntary, informed decision; for quite clearly, any decision prior to the baby's birth is, in the most important sense, uninformed, and any decision after that, compelled by a pre-existing contractual commitment, the threat of a lawsuit, and the inducement of a $10,000 payment, is less than totally voluntary. Her interests are of little concern to those who controlled this transaction.

Although the interest of the natural father and adoptive mother is certainly the predominant interest, realistically the *only* interest served, even they are left with less than what public policy requires. They know little about the natural mother, her genetic makeup, and her psychological and medical history. Moreover, not even a superficial attempt is made to determine their awareness of their responsibilities as parents.

Worst of all, however, is the contract's total disregard of the best interests of the child. There is not the slightest suggestion that any inquiry will be made at any time to determine the fitness of the Sterns as custodial parents, of Mrs. Stern as an adoptive parent, their superiority to Mrs. Whitehead, or the effect on the child of not living with her natural mother.

This is the sale of a child, or, at the very least, the sale of a mother's right to her child, the only mitigating factor being that one of the purchasers is the father. Almost every evil that prompted the prohibition on the payment of money in connection with adoptions exists here.

. . .

[A]ll parties concede that it is unlikely that surrogacy will survive without money. Despite the alleged selfless motivation of surrogate mothers, if there is no payment, there will be no surrogates, or very few. . . .

. . .

In the scheme contemplated by the surrogacy contract in this case, a middle man, propelled by profit, promotes the sale. Whatever idealism may have motivated any of the participants, the profit motive predominates, permeates, and ultimately governs the transaction. The demand for children is great and the supply small. The availability of contraception, abortion, and the greater willingness of single mothers to bring up their children has led to a shortage of babies offered for adoption. *See* N. Baker, *Baby Selling: The Scandal of Black Market Adoption, supra; Adoption and Foster Care, 1975: Hearings on Baby Selling Before the Subcommittee on Children and Youth of the Senate Committee on Labor and Public Welfare*, 94th Congress, 1st Session (1975) (Statement of Joseph H. Reid, Executive Director, Child Welfare League of America, Inc.). The situation is ripe for the entry of the middleman who will bring some equilibrium into the market by increasing the supply through the use of money.

Intimated, but disputed, is the assertion that surrogacy will be used for the benefit of the rich at the expense of the poor. *See, e.g.*, Radin, "Market Inalienability," 100 *Harv. L. Rev.* 1849, 1930 (1987). In response it is noted that the Sterns are not rich and the Whiteheads not poor. Nevertheless, it is clear to us that it is unlikely that surrogate mothers will be as proportionately numerous among those women in the top twenty percent income bracket as among those in the bottom twenty percent. Put differently, we doubt that infertile couples in the low-income bracket will find upper income surrogates.

In any event, even in this case one should not pretend that disparate wealth does not play a part simply because the contrast is not the dramatic "rich versus poor." At the time of trial, the Whiteheads' net assets were probably negative -- Mrs. Whitehead's own sister was foreclosing on a second mortgage. Their income derived from Mr. Whitehead's labors. Mrs. Whitehead is a homemaker, having previously held part-time jobs. The Sterns are both professionals, she a medical doctor, he a biochemist. Their combined income when both were working was about $89,500 a year and their assets sufficient to pay for the surrogacy contract arrangements.

The point is made that Mrs. Whitehead *agreed* to the surrogacy arrangement, supposedly fully understanding the consequences. Putting aside the issue of how compelling her need for money may have been, and how significant her understanding of the consequences, we suggest that her consent is irrelevant. There are, in a civilized society, some things that money cannot buy. In America, we decided long ago that merely because conduct purchased by money was *voluntary* did not mean that it was good or beyond regulation and prohibition. *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937). Employers can no longer buy labor at the lowest price they can bargain for, even though that labor is *voluntary*, 29 U.S.C. §206 (1982), or buy women's labor for less money than paid to men for the same job, 29 U.S.C. §206(d), or purchase the agreement of children to perform oppressive labor, 29 U.S.C. §212, or purchase the agreement of workers to subject themselves to unsafe or unhealthful working conditions, 29 U.S.C. §651 to §678. (Occupational Safety and Health Act of 1970). There are, in short, values that society deems more important than granting to wealth whatever it can buy, be it labor, love, or life. Whether this principle recommends prohibition of surrogacy, which presumably sometimes results in great satisfaction to all of the parties, is not for us to say. We note here only that, under existing law, the fact that Mrs. Whitehead *agreed* to the arrangement is not dispositive.

The long-term effects of surrogacy contracts are not known, but feared -- the impact on the child who learns her life was bought, that she is the offspring of someone who gave birth to her only to obtain money; the impact on the natural mother as the full weight of her isolation is felt along with the full reality of the sale of her body and her child; the impact on the natural father and adoptive mother once they realize the consequences of their conduct. Literature in related areas suggests these are substantial considerations, although, given the newness of surrogacy, there is little information. *See* N. Baker, *Baby Selling: The Scandal of Black Market Adoption, supra; Adoption and*

Foster Care, 1975: Hearings on Baby Selling Before the Subcommittee on Children and Youth of the Senate Common Labor and Public Welfare, 94th Congress 1st Session (1975).

The surrogacy contract is based on principles that are directly contrary to the objectives of our laws. It guarantees the separation of a child from its mother; it looks to adoption regardless of suitability; it totally ignores the child; it takes the child from the mother regardless of her wishes and her maternal fitness; and it does all of this, it accomplishes all of its goals, through the use of money.

Beyond that is the potential degradation of some women that may result from this arrangement. In many cases, of course, surrogacy may bring satisfaction, not only to the infertile couple, but to the surrogate mother herself. The fact, however, that many women may not perceive surrogacy negatively but, rather, see it as an opportunity does not diminish its potential for devastation to other women.

In sum, the harmful consequences of this surrogacy arrangement appear to us all too palpable. In New Jersey the surrogate mother's agreement to sell her child is void. Its irrevocability infects the entire contract, as does the money that purports to buy it.

III. Termination

. . .

Nothing in this record justifies a finding that would allow a court to terminate Mary Beth Whitehead's parental rights under the statutory standard. It is not simply that; obviously there was no "intentional abandonment or very substantial neglect of parental duties without a reasonable expectation of reversal of that conduct in the future," *N.J.S.A.* 9:3-48c(1); quite the contrary, but, furthermore, that the trial court never found Mrs. Whitehead an unfit mother and, indeed, affirmatively stated that Mary Beth Whitehead had been a good mother to her other children.

Although the question of best interests of the child is dispositive of the custody issue in a dispute between natural parents, it does not govern the question of termination. It has long been decided that the mere fact that a child would be better off with one set of parents than with another is an insufficient basis for terminating the natural parent's rights. . . . The parent's rights, both constitutional and statutory, have their own independent vitality.

. . .

We therefore conclude that the natural mother is entitled to retain her rights as a mother.

IV. Constitutional Issues

Both parties argue that the Constitutions -- state and federal -- mandate approval of their basic claims. The source of their constitutional arguments is essentially the same: the right of privacy, the right to procreate, the right to the companionship of one's child, those rights flowing either directly from the Fourteenth Amendment or by its incorporation of the Bill of Rights, or from the Ninth Amendment, or through the penumbra surrounding all of the Bill of Rights. They are the rights of personal intimacy, of marriage, of sex, of family, of procreation. Whatever their source, it is clear that they are fundamental rights protected by both the federal and state constitutions. *Lehr v. Robertson,* 463 U.S. 248, (1983); *Santosky v. Kramer*, 455 U.S. 745 (1982); *Zablocki v. Redhail,* 434 U.S. 374 (1978); *Quilloin v. Walcott,* 434 U.S. 246 (1978); *Carey v. Population Services International,* 431 U.S. 670, (1977); *Roe v. Wade,* 410 U.S. 113 (1973); *Stanley v. Illinois,* 405 U.S. 645, (1972); *Griswold v. Connecticut,* 381 U.S. 479 (1965); *Skinner v. Oklahoma,* 316 U.S. 535 (1942); *Meyer v. Nebraska,* 262 U.S. 390 (1923). The right asserted by the Sterns is the right of procreation; that asserted by Mary Beth Whitehead is the right to the companionship of her child. We find that the right of procreation does not extend as far as claimed by the Sterns. As for the right asserted by Mrs. Whitehead, since we uphold it on other grounds (i.e., we have restored her as mother and recognized her right, limited by the child's best interests, to her companionship), we need not decide that constitutional issue and, for reasons set forth below, we should not.

The right to procreate, as protected by the Constitution, has been ruled on directly only once by the United States Supreme Court. *See Skinner v. Oklahoma, supra.* Although *Griswold v. Connecticut, supra,* is obviously of a similar class, strictly speaking it involves the right *not* to procreate. The right to procreate very simply is the right to have natural children, whether through sexual intercourse or artificial insemination. It is no more than that. Mr. Stern has not been deprived of that right. Through artificial insemination of Mrs. Whitehead, Baby M is his child. The custody, care, companionship, and nurturing that follow birth are not parts of the right to procreation; they are rights that may also be constitutionally protected, but that involve many considerations other than the right of procreation. To assert that Mr. Stern's right of procreation gives him the right to the custody of Baby M would be to assert that Mrs. Whitehead's right of procreation does *not* give her the right to the custody of Baby M; it would be to assert that the constitutional right of procreation includes within it a constitutionally protected contractual right to destroy someone else's right of procreation.

We conclude that the right of procreation is best understood and protected if confined to its essentials, and that, when dealing with rights concerning the resulting child, different interests come into play. . . .

V. Custody

Having decided that the surrogacy contract is illegal and unenforceable, we now must decide the custody question without regard to the provisions of the surrogacy contract that would give Mr. Stern sole and permanent custody. . . . With the surrogacy contract disposed of, the legal framework becomes a dispute between two couples over the custody of a child produced by the artificial insemination of one couple's wife by the other's husband. Under the Parentage Act the claims of the natural father and the natural mother are entitled to equal weight, *i.e.*, one is not preferred over the other solely because he or she is the father or the mother. N.J.S.A. 9:17-40.[4] The applicable rule given these circumstances is clear: the child's best interests determine custody.

. . .

We are not concerned at this point with the question of termination of parental rights, either those of Mrs. Whitehead or of Mr. Stern. . . . The question of custody in this case, as in practically all cases, assumes the fitness of both parents, and no serious contention is made in this case that either is unfit. The issue here is which life would be *better* for Baby M, one with primary custody in the Whiteheads or one with primary custody in the Sterns.

The circumstances of this custody dispute are unusual and they have provoked some unusual contentions. The Whiteheads claim that even if the child's best interests would be served by our awarding custody to the Sterns, we should not do so, since that will encourage surrogacy contracts. . . . Our declaration that this surrogacy contract is unenforceable and illegal is sufficient to deter similar agreements. We need not sacrifice the child's interests in order to make that point sharper. . . .

. . .

There were 11 experts who testified concerning the child's best interests, either directly or in connection with matters related to that issue. Our reading of the record persuades us that the trial court's decision awarding custody to the Sterns (technically to Mr. Stern) should be affirmed since its findings . . . could reasonably have been reached on sufficient credible evidence present in the record. . . .

Our custody conclusion is based on strongly persuasive testimony contrasting both the family life of the Whiteheads and the Sterns and the personalities and

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[4] At common law the rights of women were so fragile that the husband generally had the paramount right to the custody of children upon separation or divorce. *State v. Baird,* 21 N.J.Eq. 384 (E. & A. 1869). In 1860, a statute concerning separation provided that children "within the age of seven years" be placed with the mother "unless said mother shall be of such character and habits as to render her an improper guardian." L.1860, c. 167. The inequities of the common-law rule and the 1860 statute were redressed by an 1871 statute, providing that "the rights of both parents, in the absence of misconduct, shall be held to be equal." N.J.S.A. 9:2-4.

characters of the individuals. The stability of the Whitehead family life was doubtful at the time of trial. Their finances were in serious trouble (foreclosure by Mrs. Whitehead's sister on a second mortgage was in process). Mr. Whitehead's employment, though relatively steady, was always at risk because of his alcoholism, a condition that he seems not to have been able to confront effectively. Mrs. Whitehead had not worked for quite some time, her last two employments having been part-time. One of the Whiteheads' positive attributes was their ability to bring up two children, and apparently well, even in so vulnerable a household. Yet substantial question was raised even about that aspect of their home life. The expert testimony contained criticism of Mrs. Whitehead's handling of her son's educational difficulties. Certain of the experts noted that Mrs. Whitehead perceived herself as omnipotent and omniscient concerning her children. She knew what they were thinking, what they wanted, and she spoke for them. . . . In short, while love and affection there would be, Baby M's life with the Whiteheads promised to be too closely controlled by Mrs. Whitehead. The prospects for wholesome, independent psychological growth and development would be at serious risk.

The Sterns have no other children, but all indications are that their household and their personalities promise a much more likely foundation for Melissa to grow and thrive. There *is* a track record of sorts -- during the one-and-a-half years of custody Baby M has done very well, and the relationship between both Mr. and Mrs. Stern and the baby has become very strong. The household is stable, and likely to remain so. Their finances are more than adequate, their circle of friends supportive, and their marriage happy. Most important, they are loving, giving, nurturing, and open-minded people. They have demonstrated the wish and ability to nurture and protect Melissa, yet at the same time to encourage her independence. Their lack of experience is more than made up for by a willingness to learn and to listen, a willingness that is enhanced by their professional training, especially Mrs. Stern's experience as a pediatrician. They are honest; they can recognize error, deal with it, and learn from it. They will try to determine rationally the best way to cope with problems in their relationship with Melissa. When the time comes to tell her about her origins, they will probably have found a means of doing so that accords with the best interests of Baby M. All in all, Melissa's future appears solid, happy, and promising with them.

Based on all of this we have concluded, independent of the trial court's identical conclusion, that Melissa's best interests call for custody in the Sterns. . . .

. . .

VI. Visitation

The trial court's decision to terminate Mrs. Whitehead's parental rights precluded it from making any determination on visitation. . . . Our reversal of the trial court's order, however, requires delineation of Mrs. Whitehead's rights to visitation. We . . .

remand the visitation issue to the trial court for an abbreviated hearing and determination as set forth below.

. . .

. . . The trial court will determine what kind of visitation shall be granted to her, with or without conditions, and when and under what circumstances it should commence. . . .

. . .

VII. Conclusion

This case affords some insight into a new reproductive arrangement: the artificial insemination of a surrogate mother. The unfortunate events that have unfolded illustrate that its unregulated use can bring suffering to all involved. Potential victims include the surrogate mother and her family, the natural father and his wife, and most importantly, the child. Although surrogacy has apparently provided positive results for some infertile couples, it can also, as this case demonstrates, cause suffering to participants, here essentially innocent and well-intended.

We have found that our present laws do not permit the surrogacy contract used in this case. Nowhere, however, do we find any legal prohibition against surrogacy when the surrogate mother volunteers, without any payment, to act as a surrogate and is given the right to change her mind and to assert her parental rights. Moreover, the legislature remains free to deal with this most sensitive issue as it sees fit, subject only to constitutional constraints.

. . .

The judgment is affirmed in part, reversed in part, and remanded for further proceedings consistent with this opinion.

BUCK v. BELL

Supreme Court of the United States, 1927
274 U.S. 200

Mr. Justice Holmes delivered the opinion of the Court.

This is a writ of error to review a judgment of the Supreme Court of Appeals of the State of Virginia, affirming a judgment of the Circuit Court of Amherst County, by which . . . the superintendent of the State Colony for Epileptics and Feeble Minded, was ordered to perform the operation of salpingectomy upon Carrie Buck . . . for the purpose of making her sterile. The case comes here upon the contention that the statute authorizing the judgment is void under the Fourteenth Amendment as denying to the plaintiff . . . due process of law and the equal protection of the laws.

Carrie Buck is a feeble-minded white woman who was committed to the State Colony. . . . She is the daughter of a feeble-minded mother in the same institution, and the mother of an illegitimate feeble-minded child. She was 18 years old at the time of the trial of her case . . . in 1924. [A Virginia law, enacted March 20, 1924] . . . recites that the health of the patient and the welfare of society may be promoted in certain cases by the sterilization of mental defectives, under careful safeguard, etc. that the sterilization may be effected in males by vasectomy and in females by salpingectomy, without serious pain or substantial danger to life; that the Commonwealth is supporting in various institutions many defective persons who if now discharged would become a menace but if incapable of procreating might be discharged with safety and become self-supporting with benefit to themselves and to society; and that experience has shown that heredity plays an important part in the transmission of insanity, imbecility, etc. The statute then enacts that whenever the superintendent of certain institutions . . . shall be of opinion that it is for the best interests of the patients and of society that an inmate under his care should be sexually sterilized, he may have the operation performed upon any patient afflicted with hereditary forms of insanity, imbecility, etc. on complying with the very careful provisions by which the Act protects the patients from possible abuse.

The superintendent first presents a petition to the special board of directors of his hospital or colony, stating the facts and the grounds for his opinion, verified by affidavit. Notice of the petition and of the time and place of the hearing in the institution is to be served upon the inmate, and also upon his guardian, and if there is no guardian the superintendent is to apply to the Circuit Court of the county to appoint one. If the inmate is a minor, notice also is to be given to his parents, if any, with a copy of the petition. The board is to see to it that the inmate may attend the hearings if desired by him or his guardian. The evidence is all to be reduced to writing, and after the board has made its order for or against the operation, the superintendent, or the inmate, or his guardian, may appeal to the Circuit Court . . . . The Circuit Court may consider the

record of the board and the evidence before it and such other admissible evidence as may be offered, and may affirm, revise, or reverse the order of the board and enter such order as it deems just. Finally, any party may . . . [appeal]. There can be no doubt that so far as procedure is concerned the rights of the patient are most carefully considered, and as every step in this case was taken in scrupulous compliance with the statute and after months of observation, there is no doubt . . . the plaintiff . . . has had due process of law.

The attack is not upon the procedure but upon the substantive law. It seems to be contended that in no circumstances could such an order be justified. It certainly is contended that the order cannot be justified upon the existing grounds. The judgment finds the facts that have been recited and that Carrie Buck "is the probable potential parent of socially inadequate offspring, likewise afflicted, that she may be sexually sterilized without detriment to her general health and that her welfare and that of society will be promoted by her sterilization . . . ."

In view of the general declarations of the legislature and the specific findings of the court, obviously we cannot say as matter of law that the grounds do not exist, and, if they exist, they justify the result.

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence.

It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. *Jacobson v. Massachusetts,* 197 U.S. 11 (1905). Three generations of imbeciles are enough.

. . .

Judgment affirmed.

BOUVIA v. SUPERIOR COURT OF LOS ANGELES COUNTY

Court of Appeal of California, 1982
225 Cal. Rptr. 297

Beach, Associate Justice

Petitioner, Elizabeth Bouvia, a patient in a public hospital, seeks the removal from her body of a nasogastric tube inserted and maintained against her will and without her consent by physicians who so placed it for the purpose of keeping her alive through involuntary forced feeding.

Petitioner has here filed a petition for writ of mandamus[5] and other extraordinary relief after the trial court denied her a preliminary injunction requiring that the tube be removed and that the hospital and doctors be prohibited from using any other similar procedures. We issued an alternative writ. We have heard oral argument from the parties and now order issuance of a peremptory writ, granting petitioner, Elizabeth Bouvia, the relief for which she prayed.

I. Discussion

A. Availability of Immediate Relief Here.

. . .

The trial court denied petitioner's request for the immediate relief she sought. It concluded that leaving the tube in place was necessary to prolong petitioner's life, and that it would, in fact, do so. With the tube in place petitioner probably will survive the time required to prepare for trial, a trial itself and an appeal, if one proved necessary. The real party-physicians also assert, and the trial court agreed, that physically petitioner tolerates the tube reasonably well and thus is not in great physical discomfort.

Real parties' counsel therefore argue that the normal course of trial and appeal provides a sufficient remedy. But petitioner's ability to tolerate physical discomfort does not diminish her right to immediate relief. . . .

To petitioner it is a dismal prospect to live with this hated and unwanted device attached to her, through perhaps years of the law's slow process. . . This matter constitutes a perfect paradigm of the axiom: "Justice delayed is justice denied."

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[5] Added. *Mandamus* is Latin and means "we command." A *writ of mandamus* directs an entity such as a board, corporation, person, or inferior court to do a particular act or restore certain privileged to the plaintiff.

. . .

Counsel for both sides have filed excellent and thorough briefs. We also have before us a voluminous record of everything submitted to the trial court. It includes the case's history; transcripts of prior proceedings; depositions; the points and authorities submitted to the trial court; and copies of statutes, policy statements, and decisions of other jurisdictions throughout the country. A further trial would establish nothing factually new. The basic and essential facts are not in serious dispute. . . .

B. Factual Background

Petitioner is a 28-year-old woman. Since birth she has been afflicted with and suffered from severe cerebral palsy. She is quadriplegic. She is now a patient at a public hospital maintained by one of the real parties in interest, the County of Los Angeles. Other parties are physicians, nurses and the medical and support staff employed by the County of Los Angeles. Petitioner's physical handicaps of palsy and quadriplegia have progressed to the point where she is completely bedridden. Except for a few fingers of one hand and some slight head and facial movements, she is immobile. She is physically helpless and wholly unable to care for herself. She is totally dependent upon others for all of her needs. These include feeding, washing, cleaning, toileting, turning, and helping her with elimination and other bodily functions. She cannot stand or sit upright in bed or in a wheelchair. She lies flat in bed and must do so the rest of her life. She suffers also from degenerative and severely crippling arthritis. She is in continual pain. Another tube permanently attached to her chest automatically injects her with periodic doses of morphine which relieves some, but not all of her physical pain and discomfort.

She is intelligent, very mentally competent. She earned a college degree. She was married but her husband has left her. She suffered a miscarriage. She lived with her parents until her father told her that they could no longer care for her. She has stayed intermittently with friends and at public facilities. A search for a permanent place to live where she might receive the constant care which she needs has been unsuccessful. She is without financial means to support herself and, therefore, must accept public assistance for medical and other care.

She has on several occasions expressed the desire to die. In 1983, she sought the right to be cared for in a public hospital in Riverside County while she intentionally *starved herself to death.* A court in that county denied her judicial assistance to accomplish that goal. She later abandoned an appeal from that ruling. Thereafter, friends took her to several different facilities, both public and private, arriving finally at her present location. Efforts by the staff of real party in interest County of Los Angeles and its social workers to find her an apartment of her own with publicly paid live-in help or regular visiting nurses to care for her, or some other suitable facility, have proved fruitless.

Petitioner must be spoon fed in order to eat. Her present medical and dietary staff have determined that she is not consuming a sufficient amount of nutrients. Petitioner stops eating when she feels she cannot swallow more without nausea and vomiting. As she cannot now retain solids, she is fed soft liquid-like food. Because of her previously announced resolve to starve herself, the medical staff feared her weight loss might reach a life-threatening level. Her weight since admission to real parties' facility seems to hover between 65 and 70 pounds. Accordingly, they inserted the subject tube against her will and contrary to her express written instructions [dictated to her lawyers, written by them and signed by her by means of her making a feeble "x" on the paper with a pen which she held in her mouth].

Petitioner's counsel argue that her weight loss was not such as to be life threatening and, therefore, the tube is unnecessary. However, the trial court found to the contrary as a matter of fact, a finding which we must accept. Nonetheless, the point is immaterial, for, as we will explain, a patient has the right to refuse any medical treatment or medical service, even when such treatment is labeled *furnishing nourishment and hydration.* This right exists even if its exercise creates a *life threatening condition.*

C. The Right to Refuse Medical Treatment.

"A person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. *Cobbs v. Grant* 502 P.2d 1 (CA, 1972). It follows that such a patient has the right to refuse any medical treatment, even that which may save or prolong her life. *Barber v. Superior Court* (1983) 195 Cal.Rptr. 484 (1983); *Bartling v. Superior Court*, 209 Cal.Rptr. 220 (1984). . . .

The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions. (California Constitution, Article I, §1; *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Bartling v. Superior Court, supra.* Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion.

. . .

. . . [S]ubstantial and respectable authority throughout the country recognize the right which petitioner seeks to exercise. Indeed, it is neither radical nor startlingly new. It is a basic and constitutionally predicated right. More than 70 years ago, Judge Benjamin Cardozo observed: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ." *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (1914).

Matter of Spring 405 N.E.2d 115 (MA, 1980); *Lane v. Candura*, 376 N.E.2d 1232 (MA, 1978); *Matter of Quackenbush*, 383 A.2d 785 (NJ, 1978); *Matter of Conroy*,

486 A.2d 1209 (NJ, 1985); *Satz v. Perlmutter*, 379 So.2d 359, aff'd. 362 So.2d 160 (FL, 1978); *In re Osborne*, 294 A.2d 372 (DC, 1972); and *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417 (MA, 1977), are but a few examples of the decisions that have upheld a patient's right to refuse medical treatment, even at risk to his health or his very life.

Further recognition that this right is paramount to even medical recommendation is evidenced by several declarations of public and professional policy which were noted in both *Barber* and *Bartling*.

. . .

Moreover, as the Bartling decision holds, there is no practical or logical reason to limit the exercise of this right to *terminal* patients. The right to refuse treatment does not need the sanction or approval by any legislative act, directing how and when it shall be exercised.

. . .

A recent Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded in part:

> The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken, just as such choices provide the basis for other decisions about medical treatment. Healthcare institutions and professionals should try to enhance patients' abilities to make decisions on their own behalf and to promote understanding of the available treatment options. . . . Healthcare professionals serve patients best by maintaining a presumption in favor of sustaining life, while recognizing that competent patients are entitled to choose to forego any treatments, including those that sustain life. (*Deciding to Forego Life-Sustaining Treatment,* at pp. 3, 5 (U.S. GPO 1983) (Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research)).

On December 11, 1985, the Los Angeles County Bar Association, and on January 6, 1986, the Los Angeles County Medical Association, recognized as general principles for decision-making the conclusions as expressly stated in the cases of *Barber* and *Bartling* and endorsed the conclusion of the Presidential Commission cited above. (*Principles and Guidelines Concerning the Foregoing of Life-Sustaining Treatment for Adult Patients.*)

The American Hospital Association Policy and Statement of Patients' Choices of Treatment Options, approved by the American Hospital Association in February of 1985 discusses the value of a collaborative relationship between the patient and the physician

and states in pertinent part: "Whenever possible, however, the authority to determine the course of treatment, if any, should rest with the patient and the right to choose treatment includes the right to refuse a specific treatment or all treatment. . . . "

. . .

Significant also is the statement adopted on March 15, 1986, by the Council on Ethical and Judicial Affairs of the American Medical Association. It is entitled *Withholding or Withdrawing Life Prolonging Medical Treatment.* In pertinent part, it declares:

> The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.

We do not believe that all of the foregoing case law and statements of policy and statutory recognition are mere lip service to a fictitious right. As noted in *Bartling, supra*:

> We do not doubt the sincerity of (the hospital and medical personnel's) moral and ethical beliefs, or their sincere belief in the position they have taken in this case. However, if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors. . . . The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged.

D. The Claimed Exceptions to the Patient's Right to Choose Are Inapplicable.

. . . [T]he real parties in interest, a county hospital, its physicians and administrators, urge that the interests of the state should prevail over the rights of Elizabeth Bouvia to refuse treatment. Advanced by real parties under this argument are the state's interests in 1) preserving life, 2) preventing suicide, 3) protecting innocent third parties, and 4) maintaining the ethical standards of the medical profession, including the right of physicians to effectively render necessary and appropriate medical service and to refuse treatment to an uncooperative and disruptive patient. . . .

. . . [W]e address ourselves briefly to some of the asserted factual differences between Mr. Bartling or patients in the other cited cases and Mrs. Bouvia. We conclude they are insufficient to deny her the right to refuse medical treatment afforded others.

. . . [T]he trial court concluded that with sufficient feeding petitioner could live an additional 15 to 20 years; therefore, the preservation of petitioner's life for that period outweighed her right to decide. In so holding, the trial court mistakenly attached undue importance to the amount of time possibly available to petitioner and failed to give equal weight and consideration for the quality of that life, an equal, if not more significant, consideration.

All decisions permitting cessation of medical treatment or life-support procedures to some degree hastened the arrival of death. In part, at least, this was permitted because the quality of life during the time remaining in those cases had been terribly diminished. In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability, and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She cannot be faulted for so concluding. If her right to choose may not be exercised because there remains to her, in the opinion of a court, a physician or some committee, a certain arbitrary number of years, months, or days, her right will have lost its value and meaning.

Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity, and purpose gone? As in all matters lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in issue.

Here Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is hers alone.

. . .

Here, if force fed, petitioner faces 15 to 20 years of a painful existence, endurable only by the constant administrations of morphine. Her condition is irreversible. There is no cure for her palsy or arthritis. Petitioner would have to be fed, cleaned, turned, bedded, toileted by others for 15 to 20 years! Although alert, bright, sensitive, perhaps even brave and feisty, she must lie immobile, unable to exist except through physical acts of others. Her mind and spirit may be free to take great flights but she herself is imprisoned and must lie physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness. We

do not believe it is the policy of this state that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live or, more accurately, endure, for 15 to 20 years. We cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone.

It is, therefore, immaterial that the removal of the nasogastric tube will hasten or cause Bouvia's eventual death. Being competent, she has the right to live out the remainder of her natural life in dignity and peace. It is precisely the aim and purpose of the many decisions upholding the withdrawal of life-support systems to accord and provide as large a measure of dignity, respect and comfort as possible to every patient for the remainder of his days, whatever be their number. This goal is not to hasten death, though its earlier arrival may be an expected and understood likelihood.

. . .

. . . [T]he trial court seriously erred by basing its decision on the "motives" behind Elizabeth Bouvia's decision to exercise her rights. If a right exists, it matters not what *motivates* its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's motives meet someone else's approval. It certainly is not illegal or immoral to prefer a natural, albeit sooner, death than a drugged life attached to a mechanical device.

[The Supreme Court of California] dealt with the matter in the case of *In re Joseph G.*, 4 Cal.Rptr. 163 (1983), wherein, declaring that the state has an interest in preserving and recognizing the sanctity of life, it observed that it is a crime to aid in suicide. But it is significant that the instances and the means there discussed all involved affirmative, assertive, proximate, direct conduct such as furnishing a gun, poison, knife, or other instrumentality or usable means by which another could physically and immediately inflict some death-producing injury upon himself. Such situations are far different than the mere presence of a doctor during the exercise of his patient's constitutional rights.

This is the teaching of *Bartling*, *supra*, and *Barber*, *supra*. No criminal or civil liability attaches to honoring a competent, informed patient's refusal of medical service.

We do not purport to establish what will constitute proper medical practice in all other cases or even other aspects of the care to be provided petitioner. We hold only that her right to refuse medical treatment, even of the life-sustaining variety, entitles her to the immediate removal of the nasogastric tube that has been involuntarily inserted into her body. The hospital and medical staff are still free to perform a substantial, if not the greater, part of their duty, i.e., that of trying to alleviate Bouvia's pain and suffering.

. . .

CANTERBURY v. SPENCE AND THE WASHINGTON HOSPITAL CENTER

United States Court of Appeals (D.C. Circuit), 1972
464 F.2d 772

Spottswood W. Robinson, III, Circuit Judge.

This appeal is from a judgment entered in the District Court on verdicts directed for the two defendants at the conclusion of plaintiff-appellant Canterbury's case in chief. His action sought damages for personal injuries allegedly sustained as a result of an operation negligently performed by defendant Spence, a negligent failure by Dr. Spence to disclose a risk of serious disability inherent in the operation, and negligent post-operative care by defendant Washington Hospital Center. . . . [Hereafter, the plaintiff-appellant Canterbury is referred to as the plaintiff, his status in the case below; and the defendants-appellees are referred to as defendants.]

I. [Facts]

The record we review tells a depressing tale. A youth troubled only by back pain submitted to an operation without being informed of a risk of paralysis incidental thereto. A day after the operation he fell from his hospital bed after having been left without assistance while voiding. A few hours after the fall, the lower half of his body was paralyzed, and he had to be operated on again. Despite extensive medical care, he has never been what he was before. Instead of the back pain, even years later, he hobbled about on crutches, a victim of paralysis of the bowels and urinary incontinence. . . .

At the time of the events which gave rise to this litigation, plaintiff was 19 years of age, a clerk-typist employed by the Federal Bureau of Investigation. In December, 1958, he began to experience severe pain between his shoulder blades. He consulted two general practitioners, but the medications they prescribed failed to eliminate the pain. Thereafter, plaintiff secured an appointment with Dr. Spence, who is a neurosurgeon.

Dr. Spence examined plaintiff in his office at some length but found nothing amiss. On Dr. Spence's advice plaintiff was x-rayed, but the films did not identify any abormality. Dr. Spence then recommended that plaintiff undergo a myelogram -- a procedure in which dye is injected into the spinal column and traced to find evidence of disease or other disorder -- at the Washington Hospital Center.

. . . The myelogram revealed a *filling defect* in the region of the fourth thoracic vertebra. Since a myelogram often does no more than pinpoint the location of an aberration, surgery may be necessary to discover the cause. Dr. Spence told plaintiff that he would have to undergo a laminectomy -- the excision of the posterior arch of the

vertebra -- to correct what he suspected was a ruptured disc. Plaintiff did not raise any objection to the proposed operation nor did he probe into its exact nature.

Plaintiff explained to Dr. Spence that his mother was a widow of slender financial means living in Cyclone, West Virginia, and that she could be reached through a neighbor's telephone. Plaintiff called his mother the day after the myelogram was performed and, failing to contact her, left Dr. Spence's telephone number with the neighbor. When Mrs. Canterbury returned the call, Dr. Spence told her that the surgery was occasioned by a suspected ruptured disc. Mrs. Canterbury then asked if the recommended operation was serious and Dr. Spence replied "not anymore than any other operation." He added that he knew Mrs. Canterbury was not well off and that her presence in Washington would not be necessary. The testimony is contradictory as to whether during the course of the conversation Mrs. Canterbury expressed her consent to the operation. Plaintiff himself apparently did not converse again with Dr. Spence prior to the operation.

Dr. Spence performed the laminectomy on February 11 at the Washington Hospital Center. Mrs. Canterbury traveled to Washington, arriving on that date but after the operation was over, and signed a consent form at the hospital. The laminectomy revealed several anomalies. . . .

For approximately the first day after the operation plaintiff recuperated normally, but then suffered a fall and an almost immediate setback. Since there is some conflict as to precisely when or why plaintiff fell, we reconstruct the events from the evidence most favorable to him. Dr. Spence left orders that plaintiff was to remain in bed during the process of voiding. These orders were changed to direct that voiding be done out of bed, and the jury could find that the change was made by hospital personnel. Just prior to the fall, plaintiff summoned a nurse and was given a receptacle for use in voiding, but was then left unattended. Plaintiff testified that during the course of the endeavor he slipped off the side of the bed, and that there was no one to assist him [and no] side rail to prevent the fall.

Several hours later, plaintiff began to complain that he could not move his legs and that he was having trouble breathing; paralysis seems to have been virtually total from the waist down. Dr. Spence was notified on the night of February 12, and he rushed to the hospital. Mrs. Canterbury signed another consent form and plaintiff was again taken into the operating room. The surgical wound was reopened and Dr. Spence created a gusset to allow the spinal cord greater room in which to pulsate.

Plaintiff's control over his muscles improved somewhat after the second operation but he was unable to void properly. As a result of this condition, he came under the care of a urologist while still in the hospital. In April, following a cystoscopic examination, plaintiff was operated on for removal of bladder stones and, in May, was released from the hospital. He reentered the hospital the following August for a 10-day period, apparently because of his urologic problems. For several years after his

discharge he was under the care of several specialists, and at all times was under the care of a urologist. At the time of the trial in April, 1968, plaintiff required crutches to walk, still suffered from urinary incontinence and paralysis of the bowels, and wore a penile clamp.

In November, 1959 on Dr. Spence's recommendation, plaintiff was transferred by the Federal Bureau of Investigation (FBI) to Miami where he could get more swimming and exercise. Plaintiff worked three years for the FBI in Miami, Los Angeles and Houston, resigning finally in June, 1962. From then until the time of the trial, he held a number of jobs, but had constant trouble finding work because he needed to remain seated and close to a bathroom. The damages plaintiff claims include extensive pain and suffering, medical expenses, and loss of earnings.

II. [The Trial]

[Canterbury] filed suit in the District Court on March 7, 1963, four years after the laminectomy and approximately two years after he attained his majority. The complaint stated several causes of action against each defendant. Against Dr. Spence it alleged, among other things, negligence in the performance of the laminectomy and failure to inform him beforehand of the risk involved. Against the hospital the complaint charged negligent post-operative care in permitting plaintiff to remain unattended after the laminectomy, in failing to provide a nurse or orderly to assist him at the time of his fall, and in failing to maintain a side rail on his bed. The answers denied the allegations of negligence and defended on the ground that the suit was barred by the statute of limitations.

. . . . Dr. Spence further testified that even without trauma paralysis can be anticipated "somewhere in the nature of one percent" of the laminectomies performed, a risk he termed "a very slight possibility." He felt that communication of that risk to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might produce adverse psychological reactions which could preclude the success of the operation.

At the close of plaintiff's case in chief, each defendant moved for a directed verdict and the trial judge granted both motions. The basis of the ruling, he explained, was that plaintiff had failed to produce any medical evidence indicating negligence on Dr. Spence's part in diagnosing plaintiff's malady or in performing the laminectomy. . . . The judge did not allude specifically to the alleged breach of duty by Dr. Spence to divulge the possible consequences of the laminectomy.

. . .

III. [The Origins of, and Rationale Behind, the Physician's Duty to Disclose]

Suits charging failure by a physician adequately to disclose the risks and alternatives of proposed treatment are not innovations in American law. *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (1914). See also *Natanson v. Kline*, 350 P.2d 1093 (KS, 1960), clarified, 354 P.2d 670 (KS, 1960); W. Prosser, *Torts* §18 at 102 (3d ed. 1964); *Restatement of Torts* §49 (1934). They date back a good half-century. . . .

The root premise is the concept, fundamental in American jurisprudence, that "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." [*Schloendorff, supra.*] True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible. [6]

A physician is under a duty to treat his patient skillfully but proficiency in diagnosis and therapy is not the full measure of his responsibility. The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it. Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition. It may call upon the physician confronting an ailment which does not respond to his ministrations to inform the patient thereof. It may command the physician to instruct the patient as to any limitations to be presently observed for his

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[6] The doctrine that a consent effective as authority to form therapy can arise only from the patient's understanding of alternatives to and risks of the therapy is commonly denominated *informed consent.* "See, e.g., Waltz & Scheuneman, "Informed Consent to Therapy," 64 *Nw.U.L.Rev.* 628 (1970). The same appellation is frequently assigned to the doctrine requiring physicians, as a matter of duty to patients, to communicate information as to such alternatives and risks. See, e.g., "Comment, Informed Consent in Medical Malpractice," 55 *Calif.L.Rev.* 1396 (1967). . . . [W]e caution that uncritical use of the *informed consent* label can be misleading.

In duty-to-disclose cases, the focus of attention is more properly upon the nature and content of the physician's divulgence than the patient's understanding or consent. Adequate disclosure and informed consent are, of course, two sides of the same coin -- the former a *sine qua non* of the latter. But the vital inquiry on duty to disclose relates to the physician's performance of an obligation, while one of the difficulties with analysis in terms of *informed consent* is its tendency to imply that what is decisive is the degree of the patient's comprehension. As we later emphasize, the physician discharges the duty when he makes a reasonable effort to convey sufficient information although the patient, without fault of the physician, may not fully grasp it. Even though the fact-finder may have occasion to draw an inference on the state of the patient's enlightenment, the fact-finding process on performance of the duty ultimately reaches back to what the physician actually said or failed to say. And, while the factual conclusion on adequacy of the revelation will vary as between patients -- as, for example, between a lay patient and a physician-patient -- the fluctuations are attributable to the kind of divulgence which may be reasonable under the circumstances.

own welfare, and as to any precautionary therapy he should seek in the future. It may oblige the physician to advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued. Just as plainly, due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.

The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.

A reasonable revelation in these respects is not only a necessity but, as we see it, [it] is . . . the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. As earlier noted, long before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital informational needs of the patient. More recently, we ourselves have found "in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know." We now find, as a part of the physician's overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.

This disclosure requirement, on analysis, reflects much more of a change in doctrinal emphasis than a substantive addition to malpractice law. It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment. Where the patient is incapable of consenting, the physician may have to obtain consent from someone else. See, e.g. *Bonner v. Moran*, 126 F.2d 121 (1941). It is also clear that the consent, to be efficacious, must be free from imposition upon the patient. See *Restatement* (Second) *of Torts* §§55-58. It is the settled rule that therapy not authorized by the patient may amount to a tort -- a common law battery -- by the physician. And, it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification. Thus, the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient. We discard the thought that the patient should ask for information before the physician is required to disclose. *Caveat emptor* is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patent's request, or merely to answer the patient's questions; it is a duty to volunteer, if necessary, the

information the patient needs for intelligent decision. The patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire. Perhaps relatively few patients could, in any event, identify the relevant questions in the absence of prior explanation by the physician. . . . The evolution of the obligation to communicate for the patient's benefit as well as the physician's protection has hardly involved an extraordinary restructuring of the law.

IV. [The Duty to Disclose (continued)]

Duty to disclose has gained recognition in a large number of American jurisdictions, but more largely on a different rationale. The majority of courts dealing with the problem have made the duty depend on whether it was the custom of physicians practicing in the community to make the particular disclosure to the patient.

. . . We agree that the physician's noncompliance with a professional custom to reveal, like any other departure from prevailing medical practice, may give rise to liability to the patient. We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition.

. . .

V. [The Scope of the Disclosure Requirement]

Once the circumstances give rise to a duty on the physician's part to inform his patient, the next inquiry is the scope of the disclosure the physician is legally obliged to make. The courts have frequently confronted this problem but no uniform standard defining the adequacy of the divulgence emerges from the decisions. Some have said *full* disclosure,[7] a norm we are unwilling to adopt literally. It seems obviously prohibitive and unrealistic to expect physicians to discuss with their patients every risk of proposed treatment -- no matter how small or remote -- and generally unnecessary from the patient's viewpoint as well. Indeed, the cases speaking in terms of *full* disclosure appear to envision something less than total disclosure, leaving unanswered the question of just how much.

The larger number of courts, as might be expected, have applied tests framed with reference to prevailing fashion within the medical profession. Some have measured the disclosure by *good medical practice*, others by what a reasonable practitioner would have bared under the circumstances, and still others by what medical custom in the community would demand. We have explored this rather considerable body of law but are unprepared to follow it. The duty to disclose, we have reasoned, arises from phenomena apart from medical custom and practice. The latter, we think, should no more establish the scope of the duty than its existence. Any definition of scope in terms

[7] E.g., *Salgo v. Leland Stanford Jr. University Board of Trustees*, 317 P.2d 170 (CA, 1957); and *Woods v. Brumlop*, 377 P.2d 520 (NM, 1962)

purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself. That prerogative, we have said, is at the very foundation of the duty to disclose, and both the patient's right to know and the physician's correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.

In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus, the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. And, to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.

Optimally for the patient, exposure of a risk would be mandatory whenever the patient would deem it significant to his decision, either singly or in combination with other risks. Such a requirement, however, would summon the physician to second-guess the patient, whose ideas on materiality could hardly be known to the physician. That would make an undue demand upon medical practitioners, whose conduct, like that of others, is to be measured in terms of reasonableness. Consonantly with orthodox negligence doctrine, the physician's liability for nondisclosure is to be determined on the basis of foresight, not hindsight; no less than any other aspect of negligence, the issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs. If, but only if, the fact-finder can say that the physician's communication was unreasonably inadequate is an imposition of liability legally or morally justified.

. . .

From these considerations we derive the breadth of the disclosure of risks legally to be required. The scope of the standard is not subjective as to either the physician or the patient; it remains objective with due regard for the patient's informational needs and with suitable leeway for the physician's situation. In broad outline, we agree that "[a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."

The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury [significance] and the degree of the harm threatened [materiality]. A

very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summon discussion with the patient.

There is no bright line separating the significant from the insignificant; the answer in any case must abide a rule of reason. Some dangers -- infection, for example -- are inherent in any operation; there is no obligation to communicate those of which persons of average sophistication are aware. Even more clearly, the physician bears no responsibility for discussion of hazards the patient has already discovered, or those having no apparent materiality to patients' decision on therapy. The disclosure doctrine, like others marking lines between permissible and impermissible behavior in medical practice, is in essence a requirement of conduct prudent under the circumstances. Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of the facts.

Two exceptions to the general rule of disclosure have been noted by the courts. Each is in the nature of a physician's privilege not to disclose, and the reasoning underlying them is appealing. Each, indeed, is but a recognition that, as important as is the patient's right to know, it is greatly outweighed by the magnitudinous circumstances giving rise to the privilege. The first comes into play when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. When a genuine emergency of that sort arises, it is settled that the impracticality of conferring with the patient dispenses with need for it. E.g., *Dunham v. Wright*, 423 F.2d 940 (1970); *Koury v. Follo*, 158 S.E.2d 548 (NC, 1968); *Woods v. Brumlop, supra*; *Gravis v. Physicians & Surgeons Hospital*, 415 S.W.2d 674 (TX, 1967). Even in situations of that character the physician should, as current law requires, attempt to secure a relative's consent if possible. See, e.g., *Bonner v. Moran, supra*, and *Koury v. Follo, supra*. But if time is too short to accommodate discussion, obviously the physician should proceed with the treatment

The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, e.g., *Roberts v. Wood*, 206 F. Supp. 579, (1962); *Nishi v. Hartwell*, 473 P.2d 116 (HI, 1970)[8]; *Woods v. Brumlop, supra*; *Ball v. Mallinkrodt*

[8] Added. Dr. Nishi's physician believed him to be suffering from an aneurysm and referred him to, Dr. Hartwell, a cardiologist. Dr. Hartwell explained the procedure to Dr. Nishi but said nothing of the collateral hazards, including a possible reaction to the contrast medium Urokon. The surgeon Dr. Scully likewise did not address the collateral hazards. The reasoning given by both was two pronged: they believed that, as a dentist, Dr. Nishi would be aware of the hazards of materials injected into the body, and they thought full disclosure was not in Dr. Nishi's best interest. (Arguably, these reasons are inherently inconsistent.) After the procedure, Dr. Nishi's lower body was paralyzed, and he had no control

Chemical Works, 381 S.W.2d 563 (TN, 1964), and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being.

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. *Scott v. Wilson*, 396 S.W.2d 532 (TX, 1965). That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself. Nor does the privilege contemplate operation save where the patient's reaction to risk information, as reasonable foreseen by the physician, is menacing. And even in a situation of that kind, disclosure to a close relative with a view to securing consent to the proposed treatment may be the only alternative open to the physician. But see, *Nishi v. Hartwell*, *supra*, and at footnote 8, *supra.*

VII. [The Role of Causality]

No more than breach of any other legal duty does nonfulfillment of the physician's obligation to disclose alone establish liability to the patient. An unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence. Occurrence of the risk must be harmful to the patient, for negligence unrelated to injury is nonactionable. And, as in malpractice actions generally, there must be a causal relationship between the physician's failure to adequately divulge and damage to the patient.

A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it. The patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils.[9] On the other hand, the very purpose of the disclosure rule is to protect the patient against consequences which, if known, he would have avoided by foregoing the treatment. The more difficult question is whether the factual issue on causality calls for an objective or a subjective determination.

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of his bladder or bowel. In the suit, his wife contended that if it was not medically appropriate for him to have been told of the risk, then she should have been told. The court held to the contrary, that a duty, if it existed, existed with regard to the patient himself and not to his spouse.

[9] Added. See *Henderson v. Milobsky*, 595 F. 2d 654 (1978). The plaintiff alleged negligence by a dentist in two respects: 1) in the extraction of a wisdom tooth and 2) in failing to disclose the possibility of permanent paresthesia. The case is notable because the plaintiff returned to the dentist for the extraction of a second wisdom tooth even though he was suffering paresthesia as a result of removal of the first. His assertion that he would not have had the first extraction had he known of the risk was clearly unreasonable. The plaintiff-appellant did lose on that point, but the case was remanded on the issue of negligence in the first extraction.

. . .

. . . [W]e believe . . . the causality issue [must be resolved] on an objective basis in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not. The patient's testimony is relevant on that score of course but it would not threaten to dominate the findings. . . .

. . .

VIII. [The Need for Expert Testimony in Nondisclosure Litigation]

. . . [M]edical facts are for medical experts and other facts are for any witnesses -- expert or not -- having sufficient knowledge and capacity to testify to them. It is evident that many of the issues typically involved in nondisclosure cases do not reside peculiarly within the medical domain. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment. Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision. . . .

IX. [Statutes of Limitation]

We now confront the question whether plaintiff's suit was barred, wholly or partly, by the statute of limitations. The statutory periods relevant to this inquiry are one year for battery actions and three years for those charging negligence. For one a minor when his cause of action accrues, they do not begin to run until he has attained his majority. Plaintiff was 19-years-old when the laminectomy and related events occurred, and he filed his complaint roughly two years after he reached majority. Consequently, any claim in suit subject to the one-year limitation came too late.

Plaintiff's causes of action for the allegedly faulty laminectomy by Dr. Spence and allegedly careless post-operative care by the hospital present no problem. Quite obviously, each was grounded in negligence and so was governed by the three-year provision. The duty-to-disclose claim plaintiff asserted against Dr. Spence, however, draws another consideration into the picture. We have previously observed that an unauthorized operation constitutes a battery and that an uninformed consent to an operation does not confer the necessary authority. If, therefore, plaintiff had at stake no more than a recovery of damages on account of a laminectomy intentionally done without intelligent permission, the statute would have interposed a bar.

It is evident, however, that plaintiff had much more at stake. His interest in bodily integrity commanded protection, not only against an intentional invasion by an

unauthorized operation but also against a negligent invasion by his physician's dereliction of duty to adequately disclose. Plaintiff has asserted and litigated a violation of that duty throughout the case. That claim, like the others, was governed by the three-year period of limitation applicable to negligence actions and was unaffected by the fact that its alternative was barred by the one-year period pertaining to batteries.

X. [Conclusion]

This brings us to the remaining question . . . whether plaintiff's evidence was of such caliber as to require a submission to the jury. . . . [We conclude that it was.]

. . .

Reversed and remanded.

CRUZAN. v. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH

Supreme Court of the United States, 1990
497 U.S. 261

Mr. Chief Justice Rehnquist delivered the opinion of the Court.[10]

Petitioner Nancy Beth Cruzan was rendered incompetent as a result of severe injuries sustained during an automobile accident. Copetitioners Lester and Joyce Cruzan, Nancy's parents and co-guardians, sought a court order directing the withdrawal of their daughter's artificial feeding and hydration equipment after it became apparent that she had virtually no chance of recovering her cognitive faculties. The Supreme Court of Missouri held that because there was no clear and convincing evidence of Nancy's desire to have life-sustaining treatment withdrawn under such circumstances, her parents lacked authority to effectuate such a request. We granted certiorari. . . .

On the night of January 11, 1983, Nancy Cruzan lost control of her car as she traveled down Elm Road in Jasper County, Missouri. The vehicle overturned, and Cruzan was discovered lying face down in a ditch. [She had no] detectable respiratory or cardiac function. Paramedics were able to restore her breathing and heartbeat at the accident site, and she was transported to a hospital in an unconscious state. An attending neurosurgeon diagnosed her as having sustained probable cerebral contusions compounded by significant anoxia (lack of oxygen). . . . She remained in a coma for approximately three weeks and then progressed to an unconscious state in which she was able to orally ingest some nutrition. In order to ease feeding and further the recovery, surgeons implanted a gastrostomy feeding and hydration tube in Cruzan with the consent of her then husband. Subsequent rehabilitative efforts proved unavailing. She now lies in a Missouri state hospital in what is commonly referred to as a persistent vegetative state:[11] generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function.[12] The State of Missouri is bearing the cost of her care.

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[10] Added from the body of the opinion. . . . Justices White, O'Connor, Scalia, and Kennedy joined. [in Chief Justice Renquist's opinion.] Justices O'Connor and Scalia filed concurring opinions; Justice Brennan filed a dissenting opinion, in which Justice Marshall and Blackman joined; and Justice Stevens filed a dissenting opinion

[11] Reordered. "*Vegetative state* describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner." *In re Jobes*, 529 A.2d 434, 438 (NJ, 1987).

[12] Reordered. The state court described Nancy's Cruzan's condition as follows:

> 1) Her respiration and circulation are not artificially maintained and are within the normal limits of a 30-year-old female; 2) she is oblivious to her environment except for reflexive responses to sound and perhaps painful stimuli; 3) she suffered anoxia of the brain resulting in a massive

After it had become apparent that Nancy Cruzan had virtually no chance of regaining her mental faculties, her parents asked hospital employees to terminate the artificial nutrition and hydration procedures. All agree that such a removal would cause her death. The employees refused to honor the request without court approval. The parents then sought and received authorization from the state trial court for termination. The court found that a person in Nancy's condition had a fundamental right under the state and federal constitutions to refuse or direct the withdrawal of *death prolonging procedures.* The court also found that Nancy's "expressed thoughts at age 25 in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition and hydration."

The Supreme Court of Missouri reversed by a divided vote. The court recognized a right to refuse treatment embodied in the common-law doctrine of informed consent, but expressed skepticism about the application of that doctrine in the circumstances of this case. The court also declined to read a broad right of privacy into the [Missouri] State Constitution which would "support the right of a person to refuse medical treatment in every circumstance," and expressed doubt as to whether such a right existed under the United States Constitution. It then decided that the Missouri Living Will statute, Mo. Rev. Stat. §459.010 *et seq.* (1986), embodied a state policy strongly favoring the preservation of life. The court found that Cruzan's statements to her roommate regarding her desire to live or die under certain conditions were "unreliable for the purpose of determining her intent, and thus insufficient to support the co-guardians' claim to exercise substituted judgment on Nancy's behalf." It rejected the argument that Cruzan's parents were entitled to order the termination of her medical

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> enlargement of the ventricles filling with cerebrospinal fluid in the area where the brain has degenerated and [her] cerebral cortical atrophy is irreversible, permanent, progressive and ongoing; 4) her highest cognitive brain function is exhibited by her grimacing perhaps in recognition of ordinarily painful stimuli, indicating the experience of pain and apparent response to sound; 5) she is a spastic quadriplegic; 6) her four extremities are contracted with irreversible muscular and tendon damage to all extremities; 7) she has no cognitive or reflexive ability to swallow food or water to maintain her daily essential needs and ... she will never recover her ability to swallow sufficient [sic] to satisfy her needs. In sum, Nancy is diagnosed as in a persistent vegetative state. She is not dead. She is not terminally ill. Medical experts testified that she could live another 30 years."

In observing that Cruzan was not dead, the court referred to the following Missouri statute:

> For all legal purposes, the occurrence of human death shall be determined in accordance with the usual and customary standards of medical practice, provided that death shall not be determined to have occurred unless the following minimal conditions have been met
>
> 1) When respiration and circulation are not artificially maintained, there is an irreversible cessation of spontaneous respiration and circulation; or
>
> 2) When respiration and circulation are artificially maintained, and there is total and irreversible cessation of all brain function, including the brain stem and that such determination is made by a licensed physician." Mo. Rev. Stat. §194.005 (1986).

treatment, concluding that "no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here." The court also expressed its view that "broad policy questions bearing on life and death are more properly addressed by representative assemblies" than judicial bodies.

We granted certiorari to consider the question whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances.

At common law, even the touching of one person by another without consent and without legal justification was a battery. See W. Keeton, D. Dobbs, R. Keeton, & D. Owen, *Prosser and Keeton on the Law of Torts* §9, pp. 39-42 (5th ed. 1984). Before the turn of the century, this Court observed that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pacific Railway Co. v. Botsford*, 141 U.S. 250 (1891). This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (NY, 1914). The informed consent doctrine has become firmly entrenched in American tort law. F. Rozovsky, *Consent to Treatment, A Practical Guide* 1-98 (2d ed. 1990).

The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment. Until about 15 years ago and the seminal decision in *In re Quinlan*, 355 A.2d 647, cert. denied *sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), the number of right-to-refuse-treatment decisions was relatively few. Most of the earlier cases involved patients who refused medical treatment forbidden by their religious beliefs, thus implicating First Amendment rights as well as common-law rights of self-determination. More recently, however, with the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned.

In the Quinlan case, young Karen Quinlan suffered severe brain damage as the result of anoxia and entered a persistent vegetative state. Karen's father sought judicial approval to disconnect his daughter's respirator. The New Jersey Supreme Court granted the relief, holding that Karen had a right of privacy grounded in the [U.S.] Constitution to terminate treatment. Recognizing that this right was not absolute, however, the court balanced it against asserted state interests. Noting that the state's interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the

prognosis dims," the court concluded that the state interests had to give way in that case. *In re Quinlan*, 355 A.2d 647, *supra,* at 664. The court also concluded that the only practical way to prevent the loss of Karen's privacy right due to her incompetence was to allow her guardian and family to decide "whether she would exercise it in these circumstances." *Ibid.*

After *Quinlan*, however, most courts have based a right to refuse treatment either solely on the common-law right to informed consent or on both the common-law right and a constitutional privacy right. See L. Tribe, *American Constitutional Law* §15-11, p. 1365 (2d ed. 1988). *In Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (MA, 1977), the Supreme Judicial Court of Massachusetts relied on both the right of privacy and the right of informed consent to permit the withholding of chemotherapy from a profoundly retarded 67-year-old man suffering from leukemia. Reasoning that an incompetent person retains the same rights as a competent individual "because the value of human dignity extends to both," the court adopted a *substituted judgment* standard whereby courts were to determine what an incompetent individual's decision would have been under the circumstances. *Id.* Distilling certain state interests from prior case law -- the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession -- the court recognized the first interest as paramount and noted it was greatest when an affliction was curable, "as opposed to the state interest where, as here, the issue is not whether, but when, for how long, and at what cost to the individual life may be briefly extended." *Id.* at 426.

In *In re Storar/Eichner,* 420 N.E.2d 64, (NY, 1981), cert. denied, 454 U.S. 858 (1981), the New York Court of Appeals declined to base a right to refuse treatment on a constitutional privacy right. Instead, it found such a right *adequately supported* by the informed consent doctrine. *Id.* at 70. In *In re Eichner* [the appeal of which was decided with the appeal of *In re Storar*], an 83-year-old man who had suffered brain damage from anoxia entered a vegetative state and was thus incompetent to consent to the removal of his respirator. The court, however, found it unnecessary to reach the question whether his rights could be exercised by others since it found the evidence clear and convincing from statements made by the patient when competent that he "did not want to be maintained in a vegetative coma by use of a respirator." *Id.* at 72. In the companion Storar case, a 52-year-old man suffering from bladder cancer had been profoundly retarded during most of his life. Implicitly rejecting the approach taken in *Saikewicz*, *supra*, the court reasoned that due to such life-long incompetency, "it is unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent." *Id.* at 72. As the evidence showed that the patient's required blood transfusions did not involve excessive pain and without them his mental and physical abilities would deteriorate, the court concluded that it should not "allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease." *Id.* at 73.

Many of the later cases build on the principles established in *Quinlan*, *Saikewicz*, and *Storar/Eichner*. For instance, in *In re Conroy*, 486 A.2d 1209 (NJ, 1985), the same court that decided Quinlan considered whether a nasogastric feeding tube could be removed from an 84-year-old incompetent nursing-home resident suffering irreversible mental and physical ailments. While recognizing that a federal right of privacy might apply in the case, the court, contrary to its approach in *Quinlan*, decided to base its decision on the common-law right to self-determination and informed consent. . . .

Reasoning that the right of self-determination should not be lost merely because an individual is unable to sense a violation of it, the court held that incompetent individuals retain a right to refuse treatment. It also held that such a right could be exercised by a surrogate decision-maker using a *subjective* standard when there was clear evidence that the incompetent person would have exercised it. Where such evidence was lacking, the court held that an individual's right could still be invoked in certain circumstances under objective *best interest* standards. *Conroy, supra,* at 1229-1233. Thus, if some trustworthy evidence existed that the individual would have wanted to terminate treatment, but not enough to clearly establish a person's wishes for purposes of the subjective standard, and the burden of a prolonged life from the experience of pain and suffering markedly outweighed its satisfactions, treatment could be terminated under a *limited-objective* standard. Where no trustworthy evidence existed, and a person's suffering would make the administration of life-sustaining treatment inhumane, a *pure-objective* standard could be used to terminate treatment. If none of these conditions obtained, the court held it was best to err in favor of preserving life. *Id.* at 1231-1233.

The court also rejected certain categorical distinctions that had been drawn in prior refusal-of-treatment cases as lacking substance for decision purposes: the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease; between treating individuals as an initial matter versus withdrawing treatment afterwards; between ordinary versus extraordinary treatment;[13] and between treatment by artificial feeding versus other forms of life-sustaining medical procedures. *Id.* at 1233-1237. As to the last item, the court acknowledged the *emotional significance* of food, but noted that feeding by implanted

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[13] Added. The phrases *ordinary* and *extraordinary medical treatment* have very technical meanings within Roman Catholic moral theology. Often, in right to refuse care cases, they are used in that sense. One should always consider carefully whether they should be given their common meaning or their technical meaning.

Technically, "[*e*]*xtraordinary means* is a bioethical term generally encompassing those drugs, devices, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience or which, if used, would offer no reasonable hope of benefit." Conversely, "*ordinary means* is a bioethical term encompassing drugs, devices, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience." [Emphasis added.] *Health Law for Federal Sector Administrators*, Glossary, Karin Waugh Zucker and Martin J. Boyle eds. (not formally published; printed by the Army Medical Department Center and School, 8th ed., 2000).

tubes is a "medical procedure with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning" which analytically was equivalent to artificial breathing using a respirator. *Id.* at 1236.

In contrast to *Conroy*, the Court of Appeals of New York recently refused to accept less than the clearly expressed wishes of a patient before permitting the exercise of her right to refuse treatment by a surrogate decision-maker. *In re Westchester County Medical Center on Behalf of O'Connor*, 531 N.E.2d 607 (NY, 1988). There, the court, over the objection of the patient's family members, granted an order to insert a feeding tube into a 77-year-old woman rendered incompetent as a result of several strokes. While continuing to recognize a common law right to refuse treatment, the court rejected the substituted judgment approach for asserting it "because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error." *Id.* at 613. The court held that the record lacked the requisite clear and convincing evidence of the patient's expressed intent to withhold life-sustaining treatment. *Id.* at 613-615.

Other courts have found state statutory law relevant to the resolution of these issues. In *Conservatorship of Drabick*, 245 Cal. Rptr. 840, cert. denied, 488 U.S. 958 (1988), the California Court of Appeal authorized the removal of a nasogastric feeding tube from a 44-year-old man who was in a persistent vegetative state as a result of an auto accident. Noting that the right to refuse treatment was grounded in both the common law and a constitutional right of privacy, the court held that a state probate statute authorized the patient's conservator to order the withdrawal of life-sustaining treatment when such a decision was made in good faith based on medical advice and the conservatee's best interests. While acknowledging that "to claim that [a patient's] *right to choose* survives incompetence is a legal fiction at best," the court reasoned that the respect society accords to persons as individuals is not lost upon incompetence and is best preserved by allowing others "to make a decision that reflects [a patient's] interests more closely than would a purely technological decision to do whatever is possible."[14] *Id.*, at 854-855. See also *In re Conservatorship of Torres*, 357 N.W.2d 332 (MN, 1984) -- the Minnesota court had constitutional and statutory authority to authorize a conservator to order the removal of an incompetent individual's respirator since [it was in the] patient's best interests.

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[14] The *Drabick* court drew support for its analysis from earlier, influential decisions rendered by California Courts of Appeal. See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (1986) -- competent 28-year-old quadriplegic had right to removal of nasogastric feeding tube inserted against her will; *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (1984) -- competent 70-year-old, seriously ill man had right to the removal of respirator); *Barber v. Superior Court*, 195 Cal. Rptr. 484 (1983) -- physicians could not be prosecuted for homicide on account of removing respirator and intravenous feeding tubes of patient in persistent vegetative state.

In *In re Estate of Longeway*, 549 N.E.2d 292, (IL, 1989), the Supreme Court of Illinois considered whether a 76-year-old woman rendered incompetent from a series of strokes had a right to the discontinuance of artificial nutrition and hydration. Noting that the boundaries of a federal right of privacy were uncertain, the court found a right to refuse treatment in the doctrine of informed consent. The court further held that the State Probate Act impliedly authorized a guardian to exercise a ward's right to refuse artificial sustenance in the event that the ward was terminally ill and irreversibly comatose. Declining to adopt a best interests standard for deciding when it would be appropriate to exercise a ward's right because it "lets another make a determination of a patient's quality of life," the court opted instead for a substituted judgment standard. *Id.* at 299. Finding the *expressed intent* standard utilized in *O'Connor, supra*, too rigid, the court noted that other clear and convincing evidence of the patient's intent could be considered. The court also adopted the "consensus opinion [that] treats artificial nutrition and hydration as medical treatment." *Id.* at 296. . . .

As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones. . . . In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did. This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a *right to die*. . . .

The Fourteenth Amendment provides that no state shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. In *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), for instance, the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the state's interest in preventing disease. . . .

. . .

But determining that a person has a liberty interest under the Due Process Clause does not end the inquiry; "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Youngberg v. Romeo*, 457 U.S. 307 (1982). See also *Mills v. Ro*gers, 457 U.S. 291 (1982).

. . . [F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Petitioners go on to assert that an incompetent person should possess the same right in this respect as is possessed by a competent person. . . .

The difficulty with petitioners' claim is that in a sense it begs the question: An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a *right* must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognized that under certain circumstances a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the state. . . .

Whether or not Missouri's clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the state may properly seek to protect in this situation. Missouri relies on its interest in the protection and preservation of human life. . . . We do not think a state is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.

. . .

But in the context presented here, a state has more particular interests at stake. The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decision-makers. And even where family members are present, "there will, of course, be some unfortunate situations in which family members will not act to protect a patient." *In re Jobes*, 529 A.2d 434, 447 (1987). A state is entitled to guard against potential abuses in such situations. . . . Finally, we think a state may properly decline to make judgments about the quality of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

In our view, Missouri has permissibly sought to advance these interests through the adoption of a *clear and convincing* standard of proof to govern such proceedings. "The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of factfinding, is to 'instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions

for a particular type of adjudication.'" *Addington v. Texas*, 441 U.S. 418 (1979) (quoting *In re Winship*, 397 U.S. 358, 370 (1970) (Harlan, J., concurring)). . . .

We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mill civil dispute. But not only does the standard of proof reflect the importance of a particular adjudication, it also serves as "a societal judgment about how the risk of error should be distributed between the litigants." *Santosky v. Kramer*, 455 U.S. 745, 756, (1982); also *Addington, supra.* The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction. . . .

. . .

In sum, we conclude that a state may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state. We note that many courts which have adopted some sort of substituted judgment procedure in situations like this, whether they limit consideration of evidence to the prior expressed wishes of the incompetent individual, or whether they allow more general proof of what the individual's decision would have been, require a clear and convincing standard of proof for such evidence. See, e.g., *Longeway, supra; McConnell v. Beverly Enterprises – Connecticut, Inc.*, 553 A.2d 596 (1989); *O'Connor, supra*; *In re Gardner*, 534 A.2d 947 (ME, 1987); *In re Jobes, supra*; *Leach v. Akron General Medical Center*, 426 N.E.2d 809 (OH, 1980).

The Supreme Court of Missouri held that in this case the testimony adduced at trial did not amount to clear and convincing proof of the patient's desire to have hydration and nutrition withdrawn. In so doing, it reversed a decision of the Missouri trial court which had found that the evidence *suggested* Nancy Cruzan would not have desired to continue such measures, but which had not adopted the standard of clear and convincing evidence enunciated by the Supreme Court. The testimony adduced at trial consisted primarily of Nancy Cruzan's statements made to a housemate about a year before her accident that she would not want to live should she face life as a *vegetable*, and other observations to the same effect. The observations did not deal in terms with withdrawal of medical treatment or of hydration and nutrition. We cannot say that the

Supreme Court of Missouri committed constitutional error in reaching the conclusion that it did.

. . .

No doubt is engendered by anything in this record but that Nancy Cruzan's mother and father are loving and caring parents. If the state were required by the United States' Constitution to repose a right of substituted judgment with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the state to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling -- a feeling not at all ignoble or unworthy, but not entirely disinterested, either -- that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the state may choose to defer only to those wishes, rather than confide the decision to close family members.[15]

The judgment of the Supreme Court of Missouri is affirmed.

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[15] We are not faced in this case with the question of whether a state might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual. . . .

IN THE MATTER OF PHILIP K. EICHNER ON BEHALF OF JOSEPH FOX[16]

Supreme Court of New York, Appellate Division, 1980
426 N.Y.S.2d 517

Opinion by Mollen, J.

This appeal concerns the right of a terminally patient in a comatose and essentially vegetative state to have extraordinary life-sustaining measures discontinued and, thereby, to permit the process of death to run its natural course. The case raises issues which involve not only the life of the patient, but the interest of the state in maintaining that life. . . . Ultimately, the question is whether the judicial system has the power to authorize termination of life-preserving measures and thereby, presumably, of life itself.

I. [Facts]

At the time this proceeding was commenced, Brother Joseph Charles Fox, an 83-year-old member of the Roman Catholic Order of the Society of Mary (S.M.), lay terminally ill in Nassau Hospital in a state which was described as a permanent or chronic vegetative coma. He had been in that state since October 2, 1979, when he suffered a cardiac arrest during surgery, with resulting severe and irreversible brain damage. The petitioner, Rev. Philip K. Eichner, S. M., thereafter instituted a proceeding pursuant to article 78 of the Mental Hygiene Law, *inter alia*, to have Brother Fox declared incompetent, and to obtain judicial approval for the withdrawal of the respirator which assisted his breathing and was believed to be solely responsible for keeping him alive.

An order approving the withdrawal of the respirator was issued by Special Term, [the court below], and the district attorney, who has opposed the petition throughout, appealed to this court. On January 24, 1980, however, shortly after the argument of this appeal, Brother Fox died of congestive heart failure despite the assistance of the respirator.

In assessing our obligations at this point, we recognize that, because the profound and difficult issues which underlie this proceeding transcend the tragedy which befell Brother Fox, they have not perished with him. . . . Brother Fox's death neither renders the case moot nor ousts this court of jurisdiction to decide it.

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[16] Added. In New York State the *Supreme Court* is actually the first level appellate court. What most of us would think of as the state's *supreme* court is the Court of Appeals of New York. The instant case was appealed again and consolidated with another case, *In the Matter of Storar*, 434 N.Y.S.2d 46 (1980). The consolidated case is found at 420 N.E.2d 64 (NY, 1981). See note 22, *infra*, at page 62.

II. [Background]

From the age of 16, Brother Joseph Charles Fox had lived a devout religious life in the Catholic Church. In 1970, he retired to the religious community of the Order of the Society of Mary living on the premises of the Chaminade High School. He had a close relationship with the president of the school, Rev. Philip Eichner, S. M., whom he had known since 1953 when Brother Fox was a prefect of novices during Father Eichner's novitiate. At the time of his retirement, Brother Fox was in excellent health suffering only from an eye condition which limited his vision. He remained both mentally and physically active, taking on duties as the high school's pastor and message co-ordinator.

In late August or early September, 1979, Brother Fox, then 83 years old, was working in the garden as was his usual practice. Apparently, in moving some large tubs of flowers, he sustained an inguinal hernia. His physician recommended that he undergo an operation and corrective surgery was scheduled for October 2, 1979. . . . The operation began and was proceeding in normal fashion when, near its conclusion, Brother Fox apparently suffered a cardiac arrest. . . . [A]s a consequence of the interruption of the flow of oxygen caused by the cardiac arrest, Brother Fox suffered substantial brain damage. He was removed to the intensive care unit of the hospital and placed on a respirator. . . .

When Father Eichner was informed of Brother Fox's dire condition, he arranged to have him examined by two neurosurgeons. Upon their negative prognosis, Father Eichner approached the hospital authorities and requested that Brother Fox be removed from the respirator. The authorities declined to comply with this request without a direction from the court and consequently Father Eichner, supported by Brother Fox's surviving relatives and members of the religious community, petitioned the court . . . to be appointed the committee[17] for Brother Fox and to be permitted to authorize discontinuance of the life-support system.

In his supporting affidavit, Father Eichner stated that . . . Brother Fox had expressed the wish that if he ever entered into a state where his brain was rendered permanently incapable of sapient or rational thought the use of extraordinary[18] life

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[17] Added. In most jurisdictions this is what would be called a *guardian*.

[18] Added. The term *extraordinary* as used here does not mean *unusual* or *uncommon*; it is part of the phrase *extraordinary means* and has a very specific meaning in Roman Catholic moral theology. "Extraordinary means is a bioethical term generally encompassing those drugs, devices, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience or which, if used, would offer no reasonable hope of benefit." Conversely, "*ordinary means* is a bioethical term encompassing drugs, devices, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience." [Emphasis added.] *Health Law for Federal Sector Administrators*, B-9, B-15, Karin Waugh Zucker and Martin Boyle eds., (not formally published; printed by the Army Medical Department Center and School, 8th ed., 2000).

support systems should be discontinued and "nature allowed to take its course." Father Eichner expressly predicated his request for termination of such extraordinary life-support systems on Brother Fox's constitutional right to privacy. Father Eichner noted that, since the medical authorities had refused to allow the exercise of that right, he was constrained to institute this proceeding for court authorization to withdraw such extraordinary and artificial life-sustaining systems.

Supporting the verified petition were affidavits by, *inter alia*, the attending physician, Dr. Edward Kelly, and a neurosurgeon, Dr. Nicholas Poloukhine, detailing the extent of irreversible brain damage suffered by Brother Fox, as well as the over-all gravity of his medical condition; specifically, he had "suffered a cardio-respiratory arrest" resulting in "diffuse cerebral and brain stem anoxia"; he was terminally ill, remaining comatose "in a permanent vegetative state and will not, in the future, come out of his permanent vegetative state." Father Eichner's verified petition was also supported by an affidavit by Norbert Mechenbier, the nephew of Brother Fox, who was acting in a representative capacity for the next-of-kin. He urged that Father Eichner be appointed for the purpose of withdrawing the extraordinary life-support systems.

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With respect to Brother Fox's views on the use of extraordinary life-sustaining measures, Father Eichner testified that in 1976, during the time that the Karen Quinlan situation was topical, the members of the Chaminade community engaged in extended discussions as to its significance, particularly in relation to the official position of the Catholic Church as expressed by the *allocution*, i.e., address, of Pope Pius XII and adopted by the New Jersey Church authorities.[19] Father Eichner indicated that Brother Fox was an active participant in those discussions, agreeing with the position expressed by these religious authorities. In particular, Father Eichner recalled one incident when he heard Brother Fox expressly declare that he "would not want any of this extraordinary business to be done for him."

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[19] On November 24, 1957, Pope Pius XII delivered an address to a group of anesthesiologists concerning the moral consequences of withdrawing "modern artificial respiration apparatus in cases of deep unconsciousness, even in those that are considered completely hopeless in the opinion of the competent doctor." The Pope stated, essentially that it was not morally sinful to use such *extraordinary* treatment for a terminal patient. However, neither was it required since such a patient need be given only *ordinary* treatment. Specifically, the Pope stated that as the use of a respirator went "beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them or to give the doctor permission to use them. There is not involved here a case of direct disposal of the life of the patient; nor of euthanasia in any way; this would never be licit. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life." *The Prolongation of Life*, Address of Pope Pius XII to an International Congress of Anesthesiologists, Nov. 24, 1957, (translation from the original French, *The Pope Speaks*, Spring 1958, vol 4, No. 4, pp. 393-398).

In opposing the petition, the district attorney sought to establish that Brother Fox was *improving* neurologically or, in the alternative, that it was too early to determine his condition because he had yet to reach a state of neurological stabilization. Toward this end the district attorney presented two physicians who had conducted a neurological examination at his request. Dr. Eli Goldensohn, a neurologist, reviewed Brother Fox's records and noted . . . that the chances were *extremely remote* and that it was entirely improbable that Brother Fox would ever regain consciousness. The witness believed death would follow in days or weeks if Brother Fox were no longer assisted by the respirator. Any improvements had been in the area of reflexes, not sapient function.

Dr. Richard Beresford, a neurologist, also examined Brother Fox, and his medical opinion was consistent with that of his colleagues. Specifically, he concluded that Brother Fox had entered into a vegetative state and it was *highly improbable* that he would ever regain cognitive function. While there was one case in the medical literature of a 43-year-old man who had fully recovered from a similar vegetative state after 17 months, this was an unexpected deviation from the normal.

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III. [Appeal from Findings Below]

In a thoughtful and extensive opinion issued on December 6, 1979, Special Term made findings of fact and conclusions of law and granted the relief sought by Father Eichner. The two key findings of fact were--

1) that . . . "to a reasonable degree of medical certainty, there is no reasonable possibility that Brother Fox will ever return from the state he is now in to a condition in which the cognitive and sapient powers of the brain -- the ability to feel, see, think, sense, communicate, feel emotions and the like -- operate. The prognosis is that Brother Fox, whether on or off the respirator, will die"; and

2) that "Brother Fox opposed the continued use of life supporting systems like respirators when the chance of recovery from a persistent vegetative state is largely nonexistent and, were he competent at this moment, he would order a termination of the life supporting respirator."

Special Term's primary conclusion of law was that Brother Fox was entitled to have the respirator withdrawn as an exercise of his common-law *right of bodily self-determination*, and although he could not personally exercise that right due to his incompetence, his committee, Father Eichner, could exercise it for him since his wishes had been made sufficiently clear, citing *Matter of Quinlan,* 355 A.2d 647 (NJ, 1976), and *Superintendent of Belchertown State School v Saikewicz*, 370 N.E.2d 417 (MA, 1977). Special Term, however, declined to recognize the right of bodily self-determination as one of constitutional dimension under the so-called right of privacy. . . An order to this effect was entered on December 12, 1979.

The district attorney has appealed from this order. . . . Subsequently, on January 24, 1980, while the decision on this appeal was pending, Brother Fox died. As previously noted, however, the controversy does not thus come to an end; we retain jurisdiction and address ourselves to the merits.

Distilling the district attorney's excellent brief into its basic elements, his argument is as follows:

1) This court does not have the power to grant the relief ultimately sought in this proceeding -- withdrawal of the respirator -- at least in the absence of legislation;

2) If this court possesses such power, neither the Constitution nor the common law gives a terminally ill patient, who is incompetent by virtue of being in a permanent vegetative coma, the right to be withdrawn from a respirator; and

3) Even if such a right exists, there was no expression of Brother Fox's intent sufficient to warrant the exercising of that right inasmuch as his purported statements of intent. . . .

IV. [Discussion]

The genesis of this case, of course, goes far beyond the operation on Brother Fox that came to a tragic conclusion. Ultimately, we must face the fact that technological advances in medicine have generally outpaced the ability of the judicial system to deal comprehensively with them in a manner consistent with the fulfillment of social policy objectives. Subjects that only 15 years ago were within the exclusive domain of such visionaries as Ray Bradbury, Arthur C. Clarke and Isaac Asimov -- genetic recombination, microsurgery, transplantation of organs and tissues -- are now very real, straining the traditional boundaries of the law. . . . And, while technological advances in medicine have achieved what to laymen are no less than miracles, it is equally true that "the struggle of medical science against death has resulted in its own peculiar horrors" (Collester, "Death, Dying and the Law: A Prosecutorial View of the *Quinlan* Case," 30 *Rutgers L. Rev.* 304). We speak of a technology that is capable of sustaining an individual in a permanent and irreversible coma for an indefinite period of time. It was the problems spawned by such technological achievements that prompted the ad hoc committee of the Harvard Medical School in 1968 to propose a re-examination of the very definition of death. . . . *Ad Hoc* Committee of Harvard Medical School to Examine the Definition of Brain Death, "A Definition of Irreversible Coma," 205 *J.A.M.A.* 337; see, also, *Matter of Quinlan, supra*; and *Matter of Dinnerstein,* 380 N.E.2d 134 (MA, 1978).

Increasingly, more are drawn to the view that, as one writer put it, the "ultimate horror is not death but the possibility of being maintained in limbo, in a sterile room, by machines controlled by strangers." Steel, "The Right to Die: New Options in California," 93 *Christian Century* July-Dec. (1976), as quoted in "Comment, North

Carolina's Natural Death Act: Confronting Death with Dignity," 14 *Wake For. L. Rev.* 771. . . . The plain fact is that medical technology capable of maintaining individuals indefinitely in a state of irreversible coma has blurred the definition of death and raised questions quite without parallel in the annals of medico-legal jurisprudence. Thus, while the law has traditionally regarded death as an *event*, i.e., the cessation of circulatory and respiratory functions, medical science has come to recognize death as a *process*. . . .

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. . . The law which embodies social policy inevitably reflects moral judgment to some degree. And, in this regard, the words of Justice Benjamin N. Cardozo are particularly apt:

> You may say that there is no assurance that judges will interpret the *mores* of their day more wisely and truly than other men. I am not disposed to deny this, but in my view it is quite beside the point. The point is rather that this power of interpretation must be lodged somewhere, and the custom of the constitution has lodged it in the judges. If they are to fulfill their function as judges, it could hardly be lodged elsewhere. Their conclusions must, indeed, be subject to constant testing and retesting, revision and readjustment; but if they act with conscience and intelligence, they ought to attain in their conclusions a fair average of truth and wisdom. --Cardozo, *The Nature of the Judicial Process*, 135-136.

[Our] Court of Appeals has long recognized the particularly urgent need for judicial vigilance in safeguarding the rights of incompetents, noting in analogous circumstances that "we cannot overlook the rights of institutional residents, especially those incapable of eloquent expression and abstract thought. These people deserve a fair hearing." *Matter of Brown v. Ristich*, 36 N.Y.2d 183, 191-192 (1975). . . .

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V. [State Interests]

Turning our attention to the substantive legal problems, we begin by recognizing that, while the right of an *incompetent* patient to refuse medical treatment or to have it withdrawn may be subject to some controversy, by contrast, the right of a *competent* patient to do so is not. There exists a solid line of case authority recognizing the undeniable right of a terminally ill but competent individual to refuse medical care, even if it will inexorably result in his death. The underlying motive for the patient's decision is irrelevant. Its legal underpinnings have been carefully considered and variously described. The Court of Appeals has affirmed that "[every] human being of adult years and sound mind has a right to determine what shall be done with his body." *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129 (1914). . . .

In some cases, however, the right to refuse medical treatment may be overridden by countervailing *compelling state interests.*[20] Thus, for example, an individual may not refuse to be vaccinated where his refusal presents a threat to the community at large. Moreover, the state's general interest in the preservation of life, coupled with its responsibility to act as *parens patriae* for minors or incompetents, may sometimes require that treatment be accepted. The interests of the state are also strongly implicated where the patient is responsible for the support of minor children and where refusal to accept treatment threatens to bring about their a*bandonment.* It has also been said that the state has a compelling interest in maintaining the ethical integrity of the medical profession by protecting physicians against the compelled violation of their professional standards and against exposure to the risk of civil or criminal liability. And, lastly, it has long been recognized that the state has an interest in discouraging irrational and wanton acts of self-destruction which violate fundamental norms of society. See Annas, "Reconciling *Quinlan* and *Saikewicz:* Decision-Making for the Terminally Ill Incompetent" 4 *Amer. J. L. & Med.* 367, 373-374; Note, "Suicide and the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases," 44 *Brooklyn L. Rev* .285.

. . . It seems clear that predicated upon the foregoing principles of common law, had Brother Fox been fully *competent* after surgery and had he refused the assistance of a respirator, his wishes would have had to be honored, absent any countervailing compelling state interest. We believe, however, that his right to refuse treatment when competent rests on a far more fundamental principle of law: the constitutional right to privacy. . . . [T]he constitutional right to privacy, we believe, encompasses the freedom of the terminally ill but competent individual to choose for himself whether or not to decline medical treatment where he reasonably believes that such treatment will only prolong his suffering needlessly, and serve merely to denigrate his conception of the quality of life. The decision by the incurably ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a fundamental decision in their lives, that it is virtually inconceivable that the right of privacy would *not* apply to it. . . . Stated in simpler and more fundamental terms, as a matter of constitutional law, a competent adult who is incurably and terminally ill has the right, if he so chooses, not to resist death and to die with dignity

Accordingly we conclude that, were Brother Fox competent, he could refuse medical treatment not only as an exercise of his common-law right but also pursuant to his constitutional right to privacy. Although the two are quite clearly equivalent in effect since they compel the same result, the difference between them is something more than mere semantics. Common-law rights can be abrogated by statute in the exercise of the state's police powers subject only to due process requirements. Constitutional rights, on the other hand, cannot be so abrogated. . . .

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[20] See *Fosmire v. Nicoleau*, 537 N.Y.S. 492 (1989), found at page 68 of this monograph.

VI. [Further Discussion of State Interests] --omitted--

VII. [Discussion of the Required Burden of Proof]

To conclude that the terminally ill, comatose patient, like his fully conscious and competent counterpart, has a right to refuse medical treatment necessarily implies that there exists a corresponding capability to exercise that right; were this not so the right would be an empty one, reduced to a meaningless *form of words*, illusory and devoid of substance. . . . Yet another difficult problem surfaces at this juncture: when and under what conditions can the terminally ill comatose patient exercise this right? The medical component clearly revolves around prognosis: when does the patient's illness become so grave and his prospects for recovery so dim, that his right to decline further treatment attaches? The legal component concerns the mechanism by which the patient's intentions are ascertained, if possible, and his best interests safeguarded.

The necessary medical criteria for the activation of the patient's right are self-apparent: he must be terminally ill; he must be in a vegetative coma characterized by the physician as *permanent*, *chronic*, or *irreversible*; he must lack cognitive brain function; and the probability of his ever regaining cognitive brain function must be extremely remote. The state's interest in protecting the sanctity of life will tolerate no less stringent medical standard than this. In this regard, however, the district attorney has raised the issue of *the burden of proof* necessary to satisfy this medical standard. He argues that nothing less than proof *beyond a reasonable doubt* will suffice to establish the appropriate medical criteria. . . . We decline to apply this standard. . . . By the same token, however, we cannot abide by the suggestion that a *preponderance of the credible evidence* standard, common to most civil proceedings, would be sufficient here. Rather, we elect the middle tier standard of proof, that of *clear and convincing evidence*. As recently discussed . . . [in] *Addington v. Texas,* 441 U.S. 418 (1979). This standard is appropriate where the "interests at stake are deemed more substantial than mere loss of money." Similarly the clear, unequivocal and convincing standard of proof is used to protect particularly important individual interests in various civil cases. See, e.g., *Woodby v. INS,* 385 U.S. 276 (1966). The exercise of the right to refuse treatment by the terminally ill comatose individual clearly falls within such *particularly important individual interests* and demands that a judicial finding be supported by the clear and convincing quantum of proof. While the qualitative meaning of the phrase, clear and convincing evidence has been variously described, we believe it requires a finding of high probability, and we are content to rest upon a recent observation by the Court of Appeals: "[The] evidentiary requirement '(operates) as a weighty caution upon the minds of all judges, and it forbids relief whenever the evidence is loose, equivocal or contradictory'." *Backer Management Corp. v. Acme Quilting Co.,* 46 N.Y.2d 211, 220 (1978), quoting *Southard v. Curley,* 134 N.Y. 148, 151 (1892). In the case at bar, there can be no dispute that the requisite standard of proof has been met.

VIII. [Implementation of the Patient's Right if there is a Clear Statement of Intent]

We turn next to an examination of the manner by which Brother Fox's right could be exercised. How can the consent of a comatose man be obtained? We cannot but emphasize that there must exist a mechanism to ascertain and to implement the patient's consent. To deny the exercise because the patient is unconscious is to deny the right. The task of ascertaining whether the patient would wish to exercise this right is, of course, considerably easier where he has unequivocally expressed a desire not to have his life prolonged beyond a certain point by artificial means; [as by a living will. However, that is often not the case.] . . .

IX. [Implementation of the Patient's Right If There is No Clear Statement of Intent]

. . . But the question does not end there for we recognize that a specific statement of intent by the patient will occur only in a minority of cases. Another mechanism is required if the comatose patient's right to refuse extraordinary life prolonging medical treatment is to be safeguarded. . . . We look particularly to a close family relative, a spouse, parent, child, brother, sister or grandchild -- in Brother Fox's case, a member of his religious family -- as an appropriate person to initiate, as committee of the incompetent, the process of reaching such a decision. Such an individual who has known and loved the patient personally, presumably for years, can best determine what that patient would have wanted under the circumstances. It is a decision we trust that will derive from a deep and abiding respect for the patient as an individual. But more important, we believe that it must be based on the assumption that the patient would have wanted it that way. This approach seeks to fulfill what would be deemed to be the dying patient's own wishes, and reaffirms notions of self-determination. The committee's responsibility in this regard is, indeed, awesome. Yet, to disregard this responsibility and to maintain the *status quo* in light of the compelling and painful circumstances would be intolerable. . . .

The final problem concerns the actual implementation of the right of the terminally ill, but comatose, patient to refuse extraordinary medical treatment. *Quinlan* and *Saikewicz* present two divergent models of implementation. [*Quinlan* recommended consultation with an ethics committee; *Saikewicz*, referral to a court.] . . .

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. . . In reaching a determination the courts *must* rely upon the medical profession in deciding the medical aspects of the problem; we recognize the primacy of the medical profession as to those aspects. But, there are other significant considerations involved, such as the wishes of the patient to the extent ascertainable, religious factors where present, the views of the family, and the concerns of society. We agree with the *Saikewicz* court that the neutral presence of the law is necessary to weigh these factors, and, thus, judicial intervention is required before any life-support system can be withdrawn. We are convinced that "questions of life and death require the process of

detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created." *Id.* at 435. Certainly, this bespeaks no distrust of the good faith or competence of the physician. . . for courts inevitably must trust the doctor's judgment as to medical prognosis. Rather, our decision recognizes that the societal interests to be safeguarded are so great that the courts have no choice but to intervene and examine each case on an *individual*, patient-to-patient basis. . . .

XI. [The Procedure to Be Followed in Such Cases]

Accordingly, we hold that the following procedure shall be applicable to the proposed withdrawal of extraordinary life-sustaining measures from the terminally ill and comatose patient. The physicians attending the patient must first certify that he is terminally ill and in an irreversible, permanent, or chronic, vegetative coma, and that the prospects of his regaining cognitive brain function are extremely remote. Thereafter, the person to whom such certification is made . . . may present the prognosis to an appropriate hospital committee. If the hospital has a standing committee for such purposes, composed of at least three physicians, then that committee shall either confirm or reject the prognosis. If the hospital has no such standing committee, then, upon the petition of the person seeking relief, the hospital's chief administrative officer shall appoint such a committee consisting of no fewer than three physicians with specialties relevant to the patient's case. Confirmation of the prognosis shall be by a majority of the members of the committee, although lack of unanimity may later be considered by the court.

Upon confirmation of the prognosis, [an individual] . . . may commence a proceeding . . . for appointment as a committee[21] of the incompetent, and for permission to have the life-sustaining measures withdrawn. The Attorney-General [of New York State] and the appropriate district attorney shall be given notice of the proceeding and, if they deem it necessary, shall be afforded an opportunity to have examinations conducted by physicians of their own choosing. Additionally, a guardian *ad litem* shall be appointed [for] . . . the patient. . . .

Where this procedure is complied with, and where the court concludes, consistent with the principles announced herein, that the extraordinary life-sustaining measures should be discontinued, no participant -- either medical or lay -- shall be subject to criminal or civil liability as a result of the termination of such life-sustaining measures. Should death occur, its proximate cause shall be deemed to be whatever caused the patient to lapse into the coma in the first instance.

We recognize that, at first blush, the procedure we require may appear cumbersome and too time-consuming to accommodate the need for speedy determinations in cases where termination of treatment is proposed. We believe,

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[21] Added. A *committee* is the term used for what would, in most jurisdictions, be termed a *guardian of the person and property*.

however, that such procedure is both necessary for the protection of the rights of the incompetent and fully capable of expeditious completion. . . .

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The order of Special Term should be modified in accordance with the foregoing opinion. As so modified, the order should be affirmed.[22]

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[22] Added. This case was appealed with another case, *In the Matter of John Storar*, 434 N.Y.S.2d 46 (1980), and reported as a consolidated case at 420 N.E.2d 64 (NY, 1981). The lower court decision regarding Brother Fox is nonetheless included in this monograph because it more completely discusses the ethical issues. Then narrative below summarizes the consolidated case.

John Storar was a profoundly retarded man, 52 years old and a resident of the Newark Development Center, a facility of the State of New Jersey. His 77-year-old, widowed mother lived nearby and visited him regularly. In 1979, physicians noticed blood in his urine. Tests revealed that he had cancer of the bladder. Mrs. Storar was appointed the guardian of her son and consented to radiation therapy for him at a hospital in Rochester. The cancer went into remission. In March 1980, blood was again noticed in his urine. The cancer was diagnosed as terminal. In May, personnel of the Center asked Mrs. Storar for permission to administer blood transfusions. At first, she refused but later agreed. John Storar thereafter received the transfusions for several weeks; until his Mrs. Storar requested that they be discontinued.

The Director of the Center then brought the proceeding below, pursuant to section 33.03 of the Mental Hygiene Law, seeking authorization to continue the transfusions. Staff physicians believed that the transfusions were necessary to replace blood lost and thought that Storar would die sooner if he did not get them. All agreed that he found the transfusions disagreeable and that he was sedated for them. There was also evidence that he appeared to feel better after receiving them, showing more energy and resuming his usual activities.

The court held that the blood transfusions should have been given. There was no evidence of what John Storar's wishes would have been. The transfusions were not excessively painful and allowed him to maintain his usual activities. It stated, "Although we understand and respect his mother's despair . . . a court should not, in the circumstances of this case, allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease."

With regard to Brother Fox (Eichner), the court found that the proper burden of proof for a decision regarding withdrawing life sustaining treatment being provided to an incompetent was clear and convincing evidence. It then found that Brother Fox's conversations regarding the Quinlan situation and the fact that he would not want to live like that were dispositive, i.e., they met the burden of proof.

The court did not reach the question of whether the right is guaranteed by the Constitution, pointing out that the matter was disputed. And, in the instant case it was not necessary to reach that question, since removal was supported by principles of common law. *In the Matter of John Storar and In the Matter of Philip Eichner v. Denis Dillon, District Attorney of Nassau County*, 420 N.W.2d 64 (NY, 1981)

FERES v. UNITED STATES

Supreme Court of the United States, 1950
340 U.S. 135

Mr. Justice Jackson delivered the opinion of the Court.

A common issue arising under the Federal Tort Claims Act, as to which Courts of Appeal are in conflict, makes it appropriate to consider three cases in one opinion.

The *Feres* case: The District Court dismissed an action by the executrix of Feres against the United States to recover for death caused by negligence. Decedent perished by fire in the barracks at Pine Camp, New York, while on active duty in service of the United States. Negligence was alleged in quartering him in barracks known or which should have been known to be unsafe because of a defective heating plant, and in failing to maintain an adequate fire watch. The Court of Appeals, Second Circuit, affirmed. . . .

The *Jefferson* case: Plaintiff, while in the Army, was required to undergo an abdominal operation. About eight months later, in the course of another operation after plaintiff was discharged, a towel 30 inches long by 18 inches wide, marked "Medical Department U.S. Army," was discovered and removed from his stomach. The complaint alleged that it was negligently left there by the Army surgeon. The District Court, being doubtful of the law, refused without prejudice the government's pretrial motion to dismiss the complaint. After trial, finding negligence as a fact, Judge Chesnut carefully reexamined the issue of law and concluded that the Act does not charge the United States with liability in this type of case. The Court of Appeals, Fourth Circuit, affirmed, 178 F.2d 518 (1949).

The *Griggs* case: The District Court dismissed the complaint of Griggs' executrix, which alleged that while on active duty he met death because of negligent and unskillful medical treatment by army surgeons. The Court of Appeals, Tenth Circuit, reversed and, with one judge dissenting, held that the complaint stated a cause of action under the Act; 178 F.2d 1 (1949).

The common fact underlying the three cases is that each claimant, while on active duty and not on furlough, sustained injury due to negligence of others in the armed forces. The only issue of law raised is whether the Tort Claims Act extends its remedy to one sustaining *incident to service* what under other circumstances would be an actionable wrong. This is the *wholly different case* reserved from our decision in *Brooks v. United States,* 337 U.S. 49 (1949).

There are few guiding materials for our task of statutory construction. No committee reports or floor debates disclose what effect the statute was designed to have on the problem before us, or that it even was in mind. Under these circumstances, no

conclusion can be above challenge, but if we misinterpret the Act, at least Congress possesses a ready remedy.

We do not overlook considerations persuasive of liability in these cases. The Act does confer district court jurisdiction generally over claims for money damages against the United States founded on negligence. 28 U.S.C. §1346 (b). It does contemplate that the government will sometimes respond for negligence of military personnel, for it defines "employee of the government" to include "members of the military or naval forces of the United States," and provides that "'acting within the scope of his office or employment', in the case of a member of the military or naval forces of the United States, means acting in line of duty." 28 U.S.C. §2671. . . . Its exceptions might also imply inclusion of claims such as we have here. . . . Significance also has been attributed . . . to the fact that 18 tort claims bills were introduced in Congress between 1925 and 1935 and all but two expressly denied recovery to members of the armed forces; but the bill enacted as the present Tort Claims Act from its introduction made no exception. . . .

This Act, however, should be construed to fit, so far as will comport with its words, into the entire statutory system of remedies against the government to make a workable, consistent, and equitable whole. The Tort Claims Act was not an isolated and spontaneous flash of congressional generosity. It marks the culmination of a long effort to mitigate unjust consequences of sovereign immunity from suit. While the political theory that the King could do no wrong was repudiated in America, a legal doctrine derived from it that the Crown is immune from any suit to which it has not consented was invoked on behalf of the Republic and applied by our courts as vigorously as it had been on behalf of the Crown. As the federal government expanded its activities, its agents caused a multiplying number of remediless wrongs -- wrongs which would have been actionable if inflicted by an individual or a corporation but remediless solely because their perpetrator was an officer or employee of the government. Relief was often sought and sometimes granted through private bills in Congress, the number of which steadily increased as government activity increased. The volume of these private bills, the inadequacy of congressional machinery for determination of facts, the importunities to which claimants subjected members of Congress, and the capricious results, led to a strong demand that claims for tort wrongs be submitted to adjudication. Congress already had waived immunity and made the government answerable for breaches of its contracts and certain other types of claims. See 28 U.S.C. §1491, often called *The Tucker Act*. At last . . . [with the Tort Claims Act], it waived immunity and transferred the burden of examining tort claims to the courts. The primary purpose of the Act was to extend a remedy to those who had been without. [I]f it incidentally benefited those already well provided for, it appears to have been unintentional. Congress was suffering from no plague of private bills on the behalf of military and naval personnel, because a comprehensive system of relief had been authorized for them and their dependents by statute.

Looking to the detail of the Act, it is true that it provides, broadly, that the District Court "shall have exclusive jurisdiction of civil actions on claims against the United States, for money damages. . . ." This confers jurisdiction to render judgment upon all such claims. But it does not say that all claims must be allowed. . . . [I]t remains for courts, in exercise of their jurisdiction, to determine whether any claim is recognizable in law.

For this purpose, the Act goes on to prescribe the test of allowable claims, which is, "The United States shall be liable . . . in the same manner and to the same extent as a private individual under like circumstances . . . ," with certain exceptions not material here. 28 U S C. §2674. It will be seen that this is not the creation of new causes of action but acceptance of liability under circumstances that would bring private liability into existence. . . . One obvious shortcoming in these claims is that plaintiffs can point to no liability of a *private individual* even remotely analogous to that which they are asserting against the United States. We know of no American law which ever has permitted a soldier to recover for negligence, against either his superior officers or the government he is serving. See *Dinsman v. Wilkes*, 53 U.S. 390 (1852); *Weaver v. Ward*, 80 Eng. Rep. 284 (1616). Nor is there any liability *under like circumstances*, for no private individual has power to conscript or mobilize a private army with such authorities over persons as the government vests in echelons of command. The nearest parallel, even if we were to treat *private individual* as including a state, would be the relationship between the states and their militia. But if we indulge plaintiffs [with] the benefit of this comparison, claimants cite us no state, and we know of none, which has permitted members of its militia to maintain tort actions for injuries suffered in the service, and in at least one state the contrary has been held to be the case. *Goldstein v. New York*, 24 N.E.2d 97 (1939). It is true that if we consider relevant only a part of the circumstances and ignore the status of both the wronged and the wrongdoer in these cases we find analogous private liability. In the usual civilian doctor and patient relationship, there is of course a liability for malpractice. [Also,] a landlord would undoubtedly be held liable if an injury occurred to a tenant as the result of a negligently maintained heating plant. But, the liability assumed by the government here is that created by *all* the circumstances, not that which a few of the circumstances might create. We find no parallel liability before, and we think no new one has been created by, this Act. Its effect is to waive immunity from recognized causes of action and was not to visit the government with novel and unprecedented liabilities.

It is not without significance as to whether the Act should be construed to apply to service-connected injuries that it makes ". . . the law of the place where the act or omission occurred" govern any consequent liability. 28 U.S.C. §1346(b). This provision recognizes and assimilates into federal law the rules of substantive law of the several states, among which divergencies are notorious. This perhaps is fair enough when the claimant is not on duty or is free to choose his own habitat and thereby limit the jurisdiction in which it will be possible for federal activities to cause him injury. That his tort claims should be governed by the law of the location where he has elected to be is just as fair when the defendant is the government as when the defendant is a

private individual. But a soldier on active duty has no such choice and must serve any place or, under modern conditions, any number of places in quick succession in the 48 states, the Canal Zone, or Alaska, or Hawaii, or any other territory of the United States. That the geography of an injury should select the law to be applied to his tort claims makes no sense. We cannot ignore the fact that most states have abolished the common-law action for damages between employer and employee and superseded it with workmen's compensation statutes which provide, in most instances, the sole basis of liability. Absent this, or where such statutes are inapplicable, states have differing provisions as to limitations of liability and different doctrines as to assumption of risk, fellow-servant rules and contributory or comparative negligence. It would hardly be a rational plan of providing for those disabled in service by others in service to leave them dependent upon geographic considerations over which they have no control and to laws which fluctuate in existence and value.

The relationship between the government and members of its armed forces is *distinctively federal in character*, as this Court recognized in *United States v. Standard Oil Co.*, 332 U.S. 301 (1947). . . . No federal law recognizes a recovery such as claimants seek. . . .

This Court, in deciding claims for wrongs incident to service under the Tort Claims Act, cannot escape attributing some bearing upon it to enactments by Congress which provide systems of simple, certain, and uniform compensation for injuries or death of those in armed services. 38 U.S.C. §701; 38 U.S.C. §718; 38 U.S.C. §725; 38 U.S.C. §731; and 38 U.S.C. (Supp III) §§740 and 741. We might say that the claimant may 1) enjoy both types of recovery, or 2) elect which to pursue, thereby waiving the other, or 3) pursue both, crediting the larger liability with the proceeds of the smaller, or 4) that the compensation and pension remedy excludes the tort remedy. There is as much statutory authority for one as for another of these conclusions. If Congress had contemplated that this Tort [Claims] Act would be held to apply in cases of this kind, it is difficult to see why it should have omitted any provision to adjust these two types of remedy to each other. The absence of any such adjustment is persuasive that there was no awareness that the Act might be interpreted to permit recovery for injuries incident to military service.

A soldier is at peculiar disadvantage in litigation. Lack of time and money, the difficulty if not impossibility of procuring witnesses, are only a few of the factors working to his disadvantage.[23] . . . The [existing] compensation system, i.e., statutory benefits, which normally requires no litigation, is not negligible or niggardly . . . as these cases demonstrate. The recoveries compare extremely favorably with those provided by most workmen's compensation statutes. . . .

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[23] To address these problems, Congress enacted the Soldiers and Sailors Civil Relief Act of 1940, last amended in 2003; 50 U.S.C. App. §501, *et seq.*

We conclude that the government is not liable under the Federal Tort Claims Act for injuries to servicemen where the injuries arise out of or are in the course of activity incident to service. Without exception, the relationship of military personnel to the government has been governed exclusively by federal law. We do not think that Congress, in drafting this Act, created a new cause of action dependent on local law for service-connected injuries or death due to negligence. We cannot impute to Congress such a radical departure from established law in the absence of express congressional command. Accordingly, the judgments in the *Feres* and *Jefferson* cases are affirmed and that in the *Griggs* case is reversed.

IN THE MATTER OF FOSMIRE v. NICOLEAU

Supreme Court of New York, Appellate Division, Second Department, 1989
536 N.Y.S.2d 492

Opinion by J. Mollen.

In this case, we are asked to review the procedures to be followed and the factors to be weighed in resolving the conflicting interests which arise when a competent adult refuses potentially lifesaving medical treatment because such treatment is in contravention of that individual's religious beliefs and/or expressed desire to be treated by alternative methods. . . .

The facts of this case are essentially undisputed. Denise J. Nicoleau, a 36-year-old pregnant practical nurse, was admitted to the Brookhaven Memorial Hospital Center (hereinafter Brookhaven Memorial) on December 29, 1988, to deliver her baby by Cesarean section. Approximately one month before her admission into the hospital, Mrs. Nicoleau, a Jehovah's Witness, executed an admission consent form prepared by Brookhaven Memorial in which she consented to the administration of various medical procedures related to the birth of her baby, but specifically excluded "the administration of blood, pooled plasma or other derivatives", which treatment was contrary to her religious beliefs.[24]Mrs. Nicoleau also informed her attending physician during her

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[24] Added. from *Health Law for Federal Sector Administrators*, 540-541, Karin Waugh Zucker and Martin J. Boyle eds. (not formally published; printed by the Army Medical Department Center and School, 8th ed., 2000).

Jehovah's Witnesses base their refusal of blood transfusions on several Biblical texts. Among those are *Leviticus* 17:10-12; *Acts* 15:28-29; and *Hebrews* 9:11-22.

> And whatsoever man there be of the house of Israel, or of the strangers that sojourn among you, that eateth any manner of blood; I will even set my face against that soul that eateth blood, and will cut him off from among his people. *Leviticus* 17: 10-12, King James Version (KJV).
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> For it seemed good to the Holy Ghost, and to us, to lay upon you no greater burden than these necessary things; that ye abstain from meats offered to idols, and from blood, and from things strangled, and from fornication; from which if ye keep yourselves, ye shall do well. *Acts* 15:28-29, KJV.
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> But Christ being come an high priest of good things to come, by a greater and more perfect tabernacle, not made with hands, that is to say, not of this building; neither by the blood of goats and calves, but by his own blood he entered in once into the holy place, having obtained eternal redemption for us. For if the blood of bulls and of goats, and the ashes of an heifer sprinkling the unclean, sanctifieth to the purifying of the flesh; how much more shall the blood of Christ, who through the eternal Spirit offered himself without spot to God, purge your conscience from dead works to serve the living God? And for this cause he is the mediator of the new testament, that by means of death, for the redemption of the trans-gressions that were under the first testament, they which are called might receive the promise of eternal inheritance. For where a testament is, there must also of necessity be the death of the testator. For a testament is of force after men are dead: otherwise it is of no strength at all while the testator liveth. Whereupon neither the first testament

pregnancy that, because of her religious beliefs, she would not consent to a blood transfusion. Mrs. Nicoleau's husband, a radiologist technician, is also a Jehovah's Witness.

Shortly after her admission to the hospital on December 29, Mrs. Nicoleau gave birth to a healthy baby boy. Later that evening, however, she experienced severe hemorrhaging from her uterus which caused her hemoglobin count to drop to approximately 4, which was well below the normal hemoglobin range of 12 to 14. In response to the attending physician's request for permission to provide Mrs. Nicoleau with a blood transfusion, both Mrs. Nicoleau and her husband refused to consent to the transfusion.

Early the next morning, Brookhaven Memorial applied for a court order authorizing the hospital to administer necessary blood transfusions to Mrs. Nicoleau. The [New York] Supreme Court, [which is the trial court in New York State,] without conducting a hearing and without in any respect communicating with the Nicoleaus or their representatives, issued an *ex parte* order[25] authorizing Brookhaven Memorial "to administer necessary blood transfusions to patient Denise Nicoleau." Shortly after the order was signed, . . . Mrs. Nicoleau was given a blood transfusion. A second transfusion was administered two days later.

Mrs. Nicoleau has now applied to this court . . . for an order vacating the [lower] court's *ex parte* order. In the supporting papers submitted on Mrs. Nicoleau's behalf by her husband and her attorney, it was explained that the decision to forego blood transfusions is premised on Mrs. Nicoleau's religious beliefs as a Jehovah's Witness, as well as the medical risks which she perceived to be involved in such transfusions, i.e., the possibility of transmitted AIDS or other infectious diseases. It was further asserted that Mrs. Nicoleau does not want to die and that while she would not consent to undergo blood transfusions, she will accept alternative nonblood medical treatments which, in some instances, are purported to be as successful as blood transfusions. . . .

We hold that the court erred in issuing its order authorizing the requested blood transfusions in the absence of notice to or an opportunity to be heard by Mrs. Nicoleau or her representatives. *Ex parte* applications are generally disfavored by the courts, unless expressly authorized by statute, because of the attendant due process implications caused by proceeding without notice. Clearly, given the important and serious nature of the rights involved in cases such as this, the court should forego taking any action on applications to administer medical treatment against the will of the patient until the

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was dedicated without blood. For when Moses had spoken every precept to all the people according to the law, he took the blood of calves and of goats, with water, and scarlet wool, and hyssop, and sprinkled both the book, and all the people, saying. 'This is the blood of the testament which God hath enjoined unto you.' Moreover he sprinkled with blood both the tabernacle, and all the vessels of the ministry. And almost all things are by the law purged with blood; and without shedding of blood is no remission. *Hebrews* 9:11-22, *KJV*.

[25] Added. An *ex parte order* is one granted by application of one party without notice to the other.

patient and/or his or her legal representatives have been notified thereof and given an opportunity to be heard. In many such instances, due to the emergency nature of the relief requested, judges have conducted their inquiry at the patient's bedside with the patient's family members and attending physicians in attendance. See, e.g., *Matter of Jamaica Hospital*, 491 N.Y.S.2d 898 (1985); and *Application of President & Directors of Georgetown College*, 331 F.2d 1000 (1964), reh. denied 331 F.2d 1010, cert. denied. Under no circumstances, however, should the court issue an order authorizing medical treatment which is known to be in violation of the patient's expressed wishes and/or religious beliefs without first making every effort to communicate with that patient or his or her representatives and to fully comprehend the patient's state of mind and wishes. . . .

. . . The underlying issue in this case, however -- i.e., under what circumstances, if any, a competent adult may be required to undergo potentially lifesaving medical treatment which is contrary to his or her expressed wishes or stated religious beliefs -- is one of public importance and, because of the expedient nature of the relief requested, often evades appellate review. . . .

The law in this state has consistently recognized that every adult of sound mind has the right to determine what shall be done to his or her own body and may decline medical treatment, even if lifesaving. See, *Matter of Westchester County Med. Center [O'Connor]*, 72 N.Y.2d 517 (1988); *Matter of Storar*, 52 N.Y.2d 363 (1981); *Schloendorff v. Society of N.Y. Hospital*, 105 N.E. 92 (NY, 1914); and *Matter of Delio v Westchester County Medical Center*, 516 N.Y.S.2d 677 (NY, 1987). Thus, even in a case involving a mentally ill patient, *Rivers v. Katz*, 67 N.Y.2d 485 (1986), the Court of Appeals held that—

> [E]ven though the recommended treatment may be beneficial or even necessary to preserve the patient's life it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires. This right extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness.

This right of self-determination must also be respected when a patient becomes physically incompetent, if it is established by clear and convincing evidence that the individual, while competent, indicated that he or she did not want certain medical procedures performed. The right of a competent adult to refuse medical treatment, even if premised upon fervently held religious beliefs, is not unqualified, however, and may be overriden by a compelling state interest.. Four compelling[26] state interests have been

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[26] Added. Please note that these four state interests would more properly be called *important*, rather than *compelling*. One might reasonably think that, if they were compelling, they would consistently trump all other interests; that is not the case -- they do not.

identified by the courts in cases involving medical treatment decisions: 1) the preservation of life, 2) the prevention of suicide, 3) the protection of innocent third parties, and 4) the maintenance of the ethical integrity of the medical profession.

. . . [E]ven if we were to assume that no other medical treatment short of a blood transfusion would have saved Mrs. Nicoleau's life, the state's interest in preserving her life is not inviolate and, in and of itself, may not, under certain circumstances, be sufficient to overcome her expressed desire to exercise her religious belief and to forego the transfusion; see *Matter of Melideo,* 88 Misc. 2d 974 (NY, 1976); *Wons v. Public Health Trust,* 500 So.2d 679 (FL, 1987). On this point, we note that this case does not present a situation in which a pregnant, adult woman refuses medical treatment and, as a result of that refusal, places the life of her unborn baby in jeopardy. Clearly, in such a case, the state's interest, as *parens patriae*, in protecting the health and welfare of the child is deemed to be paramount; *see, Matter of Jamaica Hospital, supra; Crouse Irving Memorial Hospital v. Paddock,* 415 N.Y.S.2d 443 (1985). Also distinguishable from the case at bar is the situation in which a patient refuses to affirmatively consent to a certain medical treatment based on religious beliefs, but would accept such treatment if directed by a court order. In such a case, the state interest in preserving life may well sustain the issuance of such an order; see, e.g., *Matter of Powell v. Columbian Presbyterian Medical Center,* 267 N.Y.S.2d 450(1965); *United States v. George*, 239 F Supp. 752 (1965).

Secondly, the state's concomitant interest in preventing suicide was not implicated in this case since Mrs. Nicoleau has not at any time expressed an intent to die; see *Matter of Delio v. Westchester County Medical Center, supra*; and *Matter of Eichner*, 426 N.Y.S.2d 517 (1980). To the contrary, Mrs. Nicoleau expressed her desire to continue to live but also expressed her wish for an alternative method of treatment.

The third [important] state interest, which is relied upon in large part by Brookhaven Memorial herein, is the interest of protecting innocent third parties, particularly dependent minor children. This state interest could well prove to be superior to a competent adult's right of self-determination when the exercise of that right would deprive that individual's dependents of their source of support and care (see, *Matter of Eichner [Fox], supra;* and *Matter of Delio, supra*). Thus, consideration should be given to whether the patient is the parent of a minor child and, if so, whether a surviving parent and/or members of the child's extended family are ready, willing and able to provide the necessary care and financial, familial and emotional support for that child; see, e.g., *Randolph v. City of New York,* 501 N.Y.S.2d 837 (1986), mod. 69 N.Y.2d 844 (1987); *Wons v. Public Health Trust, supra; St. Mary's Hospital v. Ramsey,* 465 So.2d 666 (FL, 1985); and *Matter of Osborne,* 294 A.2d 372 (DC, 1972). Clearly, in any case in which the state's interest in protecting minor children is involved, the court's determination is a particularly sensitive one and requires a most careful review of all relevant factors. . . . In the case at bar, however, it would appear that the state's interest in the protection of Mrs. Nicoleau's minor child would be satisfied given the

existence of a concerned and interested surviving parent, who is financially capable of supporting the child, and the existence of an involved and attentive extended family.

The fourth [important] state interest, i.e., safeguarding the ethical integrity of the medical profession, would also appear to have been satisfied under the facts of this case since the record indicates that Mrs. Nicoleau's attending physician adequately advised her and her family of the potential risks involved in foregoing blood transfusions. Moreover, Mrs. Nicoleau adequately and expressly placed Brookhaven Memorial and her attending physician on due notice as to her views on blood transfusions. Accordingly, neither Mrs. Nicoleau's physician nor Brookhaven Memorial could be deemed to have violated their professional responsibilities if they had acceded to Mrs. Nicoleau's wishes and had not administered a blood transfusion.

Finally, we emphasize that a court in addressing an application to administer blood transfusions has a responsibility to undertake the delicate and sensitive task of balancing the express wishes of the patient with the identified competing state interests and should do so only after conducting the most extensive inquiry possible under the circumstances.

GEORGIA v. McAFEE

Supreme Court of Georgia, 1989
385 S.E.2d 651

Opinion by J. Gregory.

In 1985, Larry James McAfee suffered a severe injury to his spinal cord in a motorcycle accident which left him quadriplegic. Mr. McAfee is incapable of spontaneous respiration and is dependent upon a ventilator to breathe. According to the record there is no hope that Mr. McAfee's condition will improve with time, nor is there any known medical treatment which can improve his condition.

In August 1989, Mr. McAfee filed a petition in Fulton Superior Court, seeking a determination that he be allowed to turn off his ventilator, which will result in his death. He also prayed that the ventilator not be restarted once it is disconnected. Through the assistance of an engineer, Mr. McAfee has devised a means of turning off the ventilator himself by way of a timer. He has requested that he be provided a sedative to alleviate the pain which will occur when the ventilator is disconnected.

It is not disputed that Mr. McAfee is a competent adult who has been counseled on the issues involved in this case and has discussed these issues with his family. According to the record, his family supports his decision to refuse medical treatment.

The trial court granted Mr. McAfee's petition for declaratory relief, finding his constitutional rights of privacy and liberty, *Griswold v. Connecticut,* 381 U.S. 479 (1965); 1983 Georgia Constitution, Art. I, Sec. I, Para. I, and the concomitant right to refuse medical treatment outweigh any interest the state has in this proceeding. The trial court concluded that it could not order a medical professional to administer a sedative to Mr. McAfee, but held that no civil or criminal liability would attach to anyone who did so.

In *In re L. H. R.,* 321 S.E.2d 716 (GA, 1984), this court stated that "[i]n Georgia, as elsewhere, a competent adult patient has the right to refuse medical treatment in the absence of conflicting state interest." The parties have identified four generally recognized interests of the state which must be balanced against a competent, adult patient's right to refuse medical treatment: the state's interest in preserving life; its interest in preventing suicide; preservation of the integrity of the medical profession; and protection of innocent third parties. *In re Farrell,* 529 A.2d 404 (NJ, 1987); *In re Spring,* 405 N.E.2d 115 (MA, 1980); *In re Colyer,* 660 P.2d 738 (WA, 1983); *Bartling v. Superior Court,* 209 Cal. Rptr. 220 (1984). The parties agree that the only interest of the state implicated in this case is the general interest in preserving life. The state concedes that its interest in preserving life does not outweigh Mr. McAfee's right to refuse medical treatment. Analyzing most of the decisions cited above, the state takes

the position that, "there is simply no basis in this case upon which the state may intervene and oppose the exercise of Mr. McAfee's right to refuse treatment." We note that we do not have before us a case where the state's interest is in preserving the life of an innocent third party, such as the unborn child of a woman who wishes to refuse medical treatment. See generally *Jefferson v. Griffin Spalding County Hospital Authority*, 274 S.E.2d 457 (GA, 1981). Therefore we hold that under the circumstances of this case the trial court was correct in granting Mr. McAfee's petition for declaratory relief.

We further hold that Mr. McAfee's right to be free from pain at the time the ventilator is disconnected is inseparable from his right to refuse medical treatment. The record shows that Mr. McAfee has attempted to disconnect his ventilator in the past, but has been unable to do so due to the severe pain he suffers when deprived of oxygen. His right to have a sedative (a medication that in no way causes or accelerates death) administered before the ventilator is disconnected is a part of his right to control his medical treatment.

. . .

Judgment affirmed.

GRISWOLD v. CONNECTICUT

U.S. Supreme Court, 1965
381 U.S. 479

Mr. Justice Douglas delivered the opinion of the Court.

Appellant Griswold is Executive Director of the Planned Parenthood League of Connecticut. Appellant Buxton is a licensed physician and a professor at the Yale Medical School who served as Medical Director for the League at its Center in New Haven -- a center open and operating from November 1 to November 10, 1961, when appellants were arrested.

[Appellants] gave information, instruction, and medical advice to married persons as to the means of preventing conception. They examined the wife and prescribed the best contraceptive device or material for her use. Fees were usually charged, although some couples were serviced free.

The statutes whose constitutionality is involved in this appeal are 53-32 and 54-196 of the General Statutes of Connecticut (1958 rev.). The former provides:

> Any person who uses any drug, medicinal article or instrument for the purpose of preventing conception shall be fined not less than $50.00 or imprisoned not less than 60 days nor more than one year or be both fined and imprisoned.

Section 54-196 provides:

> Any person who assists, abets, counsels, causes, hires or commands another to commit any offense may be prosecuted and punished as if he were the principal offender.

The appellants were found guilty as accessories and fined $100 each, against the claim that the accessory statute as so applied violated the Fourteenth Amendment. . . . [The judgment was affirmed by Connecticut's courts.] We noted probable jurisdiction.

We think that appellants have standing to raise the constitutional rights of the married people with whom they had a professional relationship. . . . [There is a case or controversy here in accordance with Article III of the U.S. Constitution] by reason of a criminal conviction for serving married couples in violation of an aiding-and-abetting statute. Certainly the accessory should have standing to assert that the offense which he is charged with assisting is not, or cannot constitutionally be a crime.

. . .

Coming to the merits, we are met with a wide range of questions that implicate the Due Process Clause of the Fourteenth Amendment. . . . We do not sit as a super-legislature to determine the wisdom, need, and propriety of laws that touch economic problems, business affairs, or social conditions. This law, however, operates directly on an intimate relation of husband and wife and their physician's role in one aspect of that relation.

The association of people is not mentioned in the Constitution nor in the Bill of Rights. The right to educate a child in a school of the parents' choice -- whether public or private or parochial -- is also not mentioned. Nor is the right to study any particular subject or any foreign language. Yet, the First Amendment has been construed to include certain of those rights.

By *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), the right to educate one's children as one chooses is made applicable to the states by the force of the First and Fourteenth Amendments. By *Meyer v. Nebraska*, 262 U.S. 390 (1923), the same dignity is given the right to study the German language in a private school. In other words, the state may not, consistently with the spirit of the First Amendment, contract the spectrum of available knowledge. The right of freedom of speech and press includes not only the right to utter or to print, but the right to distribute, the right to receive, the right to read (*Martin v. Struthers*, 319 U.S. 141 (1943)) and freedom of inquiry, freedom of thought, and freedom to teach (*Wieman v. Updegraff*, 344 U.S. 183 (1952)) -- indeed the freedom of the entire university community. Without those peripheral rights the specific rights would be less secure. . . .

In *NAACP v. Alabama*, 357 U.S. 449, 462 (1958) , we protected the "freedom to associate and privacy in one's associations," noting that freedom of association was a peripheral First Amendment right. Disclosure of membership lists of a constitutionally valid association, we held, was invalid "as entailing the likelihood of a substantial restraint upon the exercise by petitioner's members of their right to freedom of association." *Ibid.* In other words, the First Amendment has a penumbra where privacy is protected from governmental intrusion. In like context, we have protected forms of *association* that are not political in the customary sense but pertain to the social, legal, and economic benefit of the members. *NAACP v. Button*, 371 U.S. 415 (1963). In *Schware v. Board of Bar Examiners*, 353 U.S. 232 (1957), we held it not permissible to bar a lawyer from practice, because he had once been a member of the Communist Party. The man's "association with that Party" was not shown to be "anything more than a political faith in a political party" (*Id.* at 244) and was not action of a kind proving bad moral character. *Id.*

Those cases involved more than the *right of assembly* -- a right that extends to all irrespective of their race or ideology; *De Jonge v. Oregon*, 299 U.S. 353 (1937). The right of association, like the right of belief, *Board of Education v. Barnette*, 319 U.S. 624 (1943), is more than the right to attend a meeting; it includes the right to express one's attitudes or philosophies by membership in a group or by affiliation with it or by

other lawful means. Association in that context is a form of expression of opinion; and, while it is not expressly included in the First Amendment, its existence is necessary in making the express guarantees fully meaningful.

The foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. Various guarantees create zones of privacy. The right of association contained in the penumbra of the First Amendment is one, as we have seen. The Third Amendment in its prohibition against the quartering of soldiers *in any house* in time of peace without the consent of the owner is another facet of that privacy. The Fourth Amendment explicitly affirms the "right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures." The Fifth Amendment in its Self-Incrimination Clause enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment provides: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."

The Fourth and Fifth Amendments were described in *Boyd v. United States*, 116 U.S. 616, 630 (1886), as protection against all governmental invasions "of the sanctity of a man's home and the privacies of life." We recently referred in *Mapp v. Ohio*, 367 U.S. 643, 656 (1961), to the Fourth Amendment as creating a "right to privacy, no less important than any other right carefully and particularly reserved to the people."

The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the use of contraceptives rather than regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a "governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms." *NAACP v. Alabama*, 377 U.S. 288, 307 (1964) . Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.

We deal with a right of privacy older than the Bill of Rights -- older than our political parties, older than our school system. Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred. It is an association that promotes a way of life, not causes; a harmony in living, not political faiths; a bilateral loyalty, not commercial or social projects. Yet it is an association for as noble a purpose as any involved in our prior decisions.

Reversed.

HARRIS v. McRAE

Supreme Court of the United States, 1980
448 U.S. 297

[Mr. Justice Stewart delivered the opinion of the Court, in which Chief Justice Burger and Justices White, Powell, and Rehnquist joined.] . . .

This case presents statutory and constitutional questions concerning the public funding of abortions under Title XIX of the Social Security Act, commonly known as the Medicaid Act, and recent annual Appropriations Acts containing the so-called Hyde Amendment.[27] The statutory question is whether Title XIX requires a state that participates in the Medicaid program to fund the cost of medically necessary abortions for which federal reimbursement is unavailable under the Hyde Amendment. The constitutional question, which arises only if Title XIX imposes no such requirement, is whether the Hyde Amendment, by denying public funding for certain medically necessary abortions, contravenes the liberty or equal protection guarantees of the Due Process Clause of the Fifth Amendment, or either of the Religion Clauses of the First Amendment.

The Medicaid program was created in 1965. . . . Although participation in the Medicaid program is entirely optional, once a state elects to participate, it must comply with the requirements of Title XIX.

. . . [O]ne such requirement is that a participating state agree to provide financial assistance to the *categorically needy*[28] with respect to five general areas of medical

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[27] Added: Moved from within the text. Since September 1976, Congress has prohibited -- either by an amendment to the annual appropriations bill for the Department of Health, Education, and Welfare or by a joint resolution -- the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances. This funding restriction is commonly known as the *Hyde Amendment*, after its original congressional sponsor, Representative Henry Hyde. The current version of the Hyde Amendment, 109, 93 Stat. 926. applicable for fiscal year 1980, provides:

> [None] of the funds provided by this joint resolution shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; or except for such medical procedures necessary for the victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service.

This version of the Hyde Amendment is broader than that applicable for fiscal year 1977, which did not include the rape or incest exception, but narrower than that applicable for most of fiscal year 1978 and all of fiscal year 1979, which had an additional exception for "instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians.

[28] The *categorically needy* include families with dependent children eligible for public assistance under the Aid to Families with Dependent Children program, 42 U.S.C. §601 *et seq.*, and the aged, blind, and disabled eligible for benefits under the Supplemental Security Income program, 42 U.S.C. §1381 *et seq.* See 42 U.S.C. §1396a (a)(10)(A). Title XIX also permits a state to extend Medicaid benefits to other

treatment: 1) inpatient hospital services, 2) outpatient hospital services, 3) other laboratory and X-ray services, 4) skilled nursing facilities services, periodic screening and diagnosis of children, and family planning services, and 5) services of physicians. 42 U.S.C. §1396a (a)(13)(B) and §1396d (a)(1)-(5). Although a participating state need not "provide funding for all medical treatment falling within the five general categories, [Title XIX] does require that [a] state Medicaid [plan] establish reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX]. 42 U.S.C §1396a (a)(17)." *Beal v. Doe*, 432 U.S. 438 (1977).

On September 30, 1976, the day on which Congress enacted the initial version of the Hyde Amendment, these consolidated cases were filed in the District Court for the Eastern District of New York. The plaintiffs -- Cora McRae, a New York Medicaid recipient then in the first trimester of a pregnancy that she wished to terminate, the New York City Health and Hospitals Corporation, a public benefit corporation that operates 16 hospitals, 12 of which provide abortion services, and others -- sought to enjoin the enforcement of the funding restriction on abortions. They alleged that the Hyde Amendment violated the First, Fourth, Fifth, and Ninth Amendments of the Constitution insofar as it limited the funding of abortions to those necessary to save the life of the mother, while permitting the funding of costs associated with childbirth. . . .

After a hearing, the District Court entered a preliminary injunction prohibiting the Secretary of the Department of Health, Education, and Welfare[29] from enforcing the Hyde Amendment and requiring him to continue to provide federal reimbursement for abortions under the standards applicable before the funding restriction had been enacted. Although stating that it had not expressly held that the funding restriction was unconstitutional, since the preliminary injunction was not its final judgment, the District Court noted that such a holding was *implicit* in its decision granting the injunction. [It] also certified the . . . case as a class action on behalf of all pregnant or potentially pregnant women in the State of New York eligible for Medicaid and who decide to have an abortion within the first 24 weeks of pregnancy, and of all authorized providers of abortion services to such women.

The Secretary then brought an appeal to this Court. After deciding *Beal v. Doe, supra*, and *Maher v. Roe*, 432 U.S. 464 (1977), we vacated the injunction of the District Court and remanded the case for reconsideration in light of those decisions.

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needy persons, termed *medically needy*. See 42 U.S.C. §1396a (a)(10)(C). If a state elects to include the medically needy in its Medicaid plan, it has the option of providing somewhat different coverage from that required for the categorically needy. See 42 U.S.C. §1396a (a)(13)(C).

[29] The Department of Health, Education, and Welfare was recently reorganized and divided into the Department of Health and Human Services and the Department of Education. [Consequently, although the plaintiff, Harris, is now the Secretary of the Department of Health and Human Services.]

After a lengthy trial, which inquired into the medical reasons for abortions and the diverse religious views on the subject, the District Court filed an opinion and entered a judgment invalidating all versions of the Hyde Amendment on constitutional grounds [i.e., that it] . . . violates the equal protection component of the Fifth Amendment's Due Process Clause and the Free Exercise Clause of the First Amendment. With regard to the Fifth Amendment, the District Court noted that when an abortion is "medically necessary to safeguard the pregnant woman's health, . . . the disentitlement to [Medicaid] assistance impinges directly on the woman's right to decide, in consultation with her physician and in reliance on his judgment, to terminate her pregnancy in order to preserve her health." The court concluded that the Hyde Amendment violates the equal protection guarantee because, in its view, the decision of Congress to fund medically necessary services generally but only certain medically necessary abortions serves no legitimate governmental interest. As to the Free Exercise Clause of the First Amendment, the court held that insofar as a woman's decision to seek a medically necessary abortion may be a product of her religious beliefs under certain Protestant and Jewish tenets, the funding restrictions of the Hyde Amendment violate that constitutional guarantee as well.

Accordingly, the District Court ordered the Secretary to "[cease] to give effect" to the various versions of the Hyde Amendment insofar as they forbid payments for medically necessary abortions. It further directed the Secretary to "[continue] to authorize the expenditure of federal matching funds [for such abortions]. . . .

The Secretary then applied to this Court for a stay of the judgment pending direct appeal of the District Court's decision. We denied the stay . . . [but agreed to hear the case.]

. . . [W]e turn first to the question [of] whether Title XIX requires a state that participates in the Medicaid program to continue to fund those medically necessary abortions for which federal reimbursement is unavailable under the Hyde Amendment. If a participating state is under such an obligation, the constitutionality of the Hyde Amendment need not be drawn into question in the present case, for the availability of medically necessary abortions under Medicaid would continue, with the participating state shouldering the total cost of funding such abortions.

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. . . The Medicaid program created by Title XIX is a cooperative endeavor in which the federal government provides financial assistance to participating states to aid them in furnishing healthcare to needy persons. Under this system *of cooperative federalism*, if a state agrees to establish a Medicaid plan that satisfies the requirements of Title XIX, which include several mandatory categories of health services, the federal government agrees to pay a specified percentage of "the total amount expended ... as medical assistance under the state plan." 42 U.S.C. §1396b (a)(1). The cornerstone of Medicaid is financial contribution by both the federal government and the participating

state. Nothing in Title XIX as originally enacted, or in its legislative history, suggests that Congress intended to require a participating state to assume the full costs of providing any health services in its Medicaid plan. Quite the contrary, the purpose of Congress in enacting Title XIX was to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan. See S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, pp. 83-85 (1965); H. R. Rep. No. 213, 89th Cong., 1st Sess., 72-74 (1965).

Since the Congress that enacted Title XIX did not intend a participating state to assume a unilateral funding obligation for any health service in an approved Medicaid plan, it follows that Title XIX does not require a participating state to include in its plan any services for which a subsequent Congress has withheld federal funding. Title XIX was designed as a cooperative program of shared financial responsibility, not as a device for the federal government to compel a state to provide services that Congress itself is unwilling to fund. Thus, if Congress chooses to withdraw federal funding for a particular service, a state is not obliged to continue to pay for that service as a condition of continued federal financial support of other services. This is not to say that Congress may not now depart from the original design of Title XIX under which the federal government shares the financial responsibility for expenses incurred under an approved Medicaid plan. It is only to say that, absent an indication of contrary legislative intent by a subsequent Congress, Title XIX does not obligate a participating state to pay for those medical services for which federal reimbursement is unavailable.

. . . Accordingly, we conclude that Title XIX does not require a participating state to pay for those medically necessary abortions for which federal reimbursement is unavailable under the Hyde Amendment.

Having determined that Title XIX does not obligate a participating state to pay for those medically necessary abortions for which Congress has withheld federal funding, we must consider the constitutional validity of the Hyde Amendment. The appellees assert that the funding restrictions of the Hyde Amendment violate several rights secured by the Constitution -- 1) the right of a woman, implicit in the Due Process Clause of the Fifth Amendment, to decide whether to terminate a pregnancy, 2) the prohibition under the Establishment Clause of the First Amendment against any "law respecting an establishment of religion," and 3) the right to freedom of religion protected by the Free Exercise Clause of the First Amendment. The appellees also contend that, quite apart from substantive constitutional rights, the Hyde Amendment violates the equal protection component of the Fifth Amendment.

It is well settled that, quite apart from the guarantee of equal protection, if a law "impinges upon a fundamental right explicitly or implicitly secured by the Constitution [it] is presumptively unconstitutional." *Mobile v. Bolden,* 446 U.S. 55 (1980). Accordingly, before turning to the equal protection issue in this case, we examine whether the Hyde Amendment violates any substantive rights secured by the Constitution.

A. [Challenge Based on the Due Process Clause]

We address first the appellees' argument that the Hyde Amendment, by restricting the availability of certain medically necessary abortions under Medicaid, impinges on the *liberty* protected by the Due Process Clause as recognized in *Roe v. Wade,* 410 U.S. 113 (1973), and its progeny.

In [*Roe*], this Court held unconstitutional a Texas statute making it a crime to procure or attempt an abortion except on medical advice for the purpose of saving the mother's life. The constitutional underpinning of [*Roe*] was a recognition that the *liberty* protected by the Due Process Clause of the Fourteenth Amendment includes not only the freedoms explicitly mentioned in the Bill of Rights, but also a freedom of personal choice in certain matters of marriage and family life. Marriage -- *Loving v. Virginia*, 388 U.S.1 (1967); procreation -- *Skinner v. Oklahoma*, 316 U.S. 535 (1942); contraception -- *Eisenstadt v. Baird*, 405 U.S. 438 (1972); and child rearing and education -- *Pierce v. Society of Sisters*, 268 U.S. 510 (1925). This implicit constitutional liberty, the Court in [*Roe*] held, includes the freedom of a woman to decide whether to terminate a pregnancy.

But the Court in [*Roe*] also recognized that a state has legitimate interests during a pregnancy in both ensuring the health of the mother and protecting potential human life. These state interests, which were found to be *separate and distinct* and to "[grow] in substantiality as the woman approaches term," pose a conflict with a woman's untrammeled freedom of choice. In resolving this conflict, the Court held that before the end of the first trimester of pregnancy, neither state interest is sufficiently substantial to justify any intrusion on the woman's freedom of choice. In the second trimester, the state interest in maternal health was found to be sufficiently substantial to justify regulation reasonably related to that concern. And, at viability, usually in the third trimester, the state interest in protecting the potential life of the fetus was found to justify a criminal prohibition against abortions, except where necessary for the preservation of the life or health of the mother.[30] Thus, inasmuch as the Texas criminal statute allowed abortions only where necessary to save the life of the mother and without regard to the stage of the pregnancy, the Court held in [*Roe*] that the statute violated the Due Process Clause of the Fourteenth Amendment.

In *Maher v. Roe*, 432 U.S. 464 (1977), the Court was presented with the question whether the scope of personal constitutional freedom recognized in *Roe* included an entitlement to Medicaid payments for abortions that are not medically necessary. At issue in *Maher* was a Connecticut welfare regulation under which Medicaid recipients

[30] Added. This is not what the Court said in *Roe*, but it may well be the source of numerous references to *Roe's* three trimester system. As you may remember, there is no three trimester system in *Roe*. While *Roe* does divide pregnancy into three periods, only the first is identified as a trimester. Rather, the periods of pregnancy for purposes of the rules laid down in *Roe* are: 1) from conception to the end of the first trimester; 2) from the end of the first trimester to viability; and 3) from viability to birth. Further, viability is not a point set by length of gestation but may well change, and has changed, based upon advances in medicine and technology.

received payments for medical services incident to childbirth, but not for medical services incident to nontherapeutic abortions. . . . As [this] Court elaborated:

> The Connecticut regulation before us is different in kind from the laws invalidated in our previous abortion decisions. The Connecticut regulation places no obstacles -- absolute or otherwise -- in the pregnant woman's path to an abortion. An indigent woman who desires an abortion suffers no disadvantage as a consequence of Connecticut's decision to fund childbirth; she continues as before to be dependent on private sources for the service she desires. The state may have made childbirth a more attractive alternative, thereby influencing the woman's decision, but it has imposed no restriction on access to abortions that was not already there. The indigency that may make it difficult -- and in some cases, perhaps, impossible -- for some women to have abortions is neither created nor in any way affected by the Connecticut regulation.

The Court in *Maher* noted that its description of the doctrine recognized in *Wade* and its progeny signaled *no retreat* from those decisions. In explaining why the constitutional principle recognized in [*Roe*] and later cases -- protecting a woman's freedom of choice -- did not translate into a constitutional obligation of Connecticut to subsidize abortions, the Court cited the "basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy." Constitutional concerns are greatest when the state attempts to impose its will by force of law; the state's power to encourage actions deemed to be in the public interest is necessarily far broader. Thus, even though the Connecticut regulation favored childbirth over abortion by means of subsidization of one and not the other, the Court in *Maher* concluded that the regulation did not impinge on the constitutional freedom recognized in [*Roe*] because it imposed no governmental restriction on access to abortions.

The Hyde Amendment, like the Connecticut welfare regulation at issue in *Maher*, places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy, but rather, by means of unequal subsidization of abortion and other medical services, encourages alternative activity deemed in the public interest. The present case does differ factually from *Maher* insofar as that case involved a failure to fund nontherapeutic abortions, whereas the Hyde Amendment withholds funding of certain medically necessary abortions. Accordingly, the appellees argue that because the Hyde Amendment affects a significant interest not present or asserted in *Maher* -- the interest of a woman in protecting her health during pregnancy -- and because that interest lies at the core of the personal constitutional freedom recognized in [*Roe*], the present case is constitutionally different from *Maher*. . . .

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. . . [I]t simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices. The reason why was explained in *Maher*: Although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category. The financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather of her indigency. Although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the fact remains that the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health- care costs at all. We are thus not persuaded that the Hyde Amendment impinges on the constitutionally protected freedom of choice recognized in *Roe*.

Although the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom. To hold otherwise would mark a drastic change in our understanding of the Constitution. It cannot be that because government may not prohibit the use of contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965), or prevent parents from sending their child to a private school, *Pierce v. Society of Sisters, supra,* government, therefore, has an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives or send their children to private schools. To translate the limitation on governmental power implicit in the Due Process Clause into an affirmative funding obligation would require Congress to subsidize the medically necessary abortion of an indigent woman even if Congress had not enacted a Medicaid program to subsidize other medically necessary services. Nothing in the Due Process Clause supports such an extraordinary result. Whether freedom of choice that is constitutionally protected warrants federal subsidization is a question for Congress to answer, not a matter of constitutional entitlement. Accordingly, we conclude that the Hyde Amendment does not impinge on the due process liberty recognized in *Roe*.

B. [Challenge Based on the Religion Clauses]

The appellees also argue that the Hyde Amendment contravenes rights secured by the Religion Clauses of the First Amendment. It is the appellees' view that the Hyde Amendment violates the Establishment Clause because it incorporates into law the doctrines of the Roman Catholic Church concerning the sinfulness of abortion and the time at which life commences. Moreover, insofar as a woman's decision to seek a medically necessary abortion may be a product of her religious beliefs under certain Protestant and Jewish tenets, the appellees assert that the funding limitations of the Hyde Amendment impinge on the freedom of religion guaranteed by the Free Exercise Clause.

1. [Establishment of Religion]

It is well settled that "a legislative enactment does not contravene the Establishment Clause if it has a secular legislative purpose, if its principal or primary effect neither advances nor inhibits religion, and if it does not foster an excessive governmental entanglement with religion." *Committee for Public Education v. Regan,* 444 U.S. 646 (1980). Applying this standard, the District Court properly concluded that the Hyde Amendment does not run afoul of the Establishment Clause. Although neither a state nor the federal government can constitutionally "pass laws which aid one religion, aid all religions, or prefer one religion over another," *Everson v. Board of Education,* 330 U.S. 1 (1947), it does not follow that a statute violates the Establishment Clause because it "happens to coincide or harmonize with the tenets of some or all religions." *McGowan v. Maryland,* 366 U.S. 420 (1961). That the Judaeo-Christian religions oppose stealing does not mean that a state or the federal government may not, consistent with the Establishment Clause, enact laws prohibiting larceny. *Ibid.* The Hyde Amendment, as the District Court noted, is as much a reflection of *traditionalist* values towards abortion, as it is an embodiment of the views of any particular religion. In sum, we are convinced that the fact that the funding restrictions in the Hyde Amendment may coincide with the religious tenets of the Roman Catholic Church does not, without more, contravene the Establishment Clause.

2. [Free Exercise of Religion]

We need not address the merits of the appellees' arguments concerning the Free Exercise Clause, because the appellees lack standing to raise a free exercise challenge to the Hyde Amendment. [The indigent pregnant women did not allege that they sought abortions under compulsion of religious belief; the two officers of the Woman's Division did provide a detailed description of their religious beliefs, failed to allege that they are or plan to become pregnant or that they are eligible for Medicaid; the others did not argue the Free Exercise Clause.] . . .

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C. Challenge Based on the Equal Protection Clause

It remains to be determined whether the Hyde Amendment violates the equal protection component of the Fifth Amendment. This challenge is premised on the fact that, although federal reimbursement is available under Medicaid for medically necessary services generally, the Hyde Amendment does not permit federal reimbursement of all medically necessary abortions. The District Court held, and the appellees argue here, that this selective subsidization violates the constitutional guarantee of equal protection.

The guarantee of equal protection under the Fifth Amendment is not a source of substantive rights or liberties, but rather a right to be free from invidious discrimination

in statutory classifications and other governmental activity. It is well settled that where a statutory classification does not itself impinge on a right or liberty protected by the Constitution, the validity of classification must be sustained unless "the classification rests on grounds wholly irrelevant to the achievement of [any legitimate governmental] objective." *McGowan v. Maryland, supra.* This presumption of constitutional validity, however, disappears if a statutory classification is predicated on criteria that are, in a constitutional sense, *suspect*, the principal example of which is a classification based on race, e. g., *Brown v. Board of Education,* 347 U.S. 483 (1954).

For the reasons stated above, we have already concluded that the Hyde Amendment violates no constitutionally protected substantive rights. We now conclude as well that it is not predicated on a constitutionally suspect classification. In reaching this conclusion, we again draw guidance from the Court's decision in *Maher v. Roe, supra.* . . .

> An indigent woman desiring an abortion does not come within the limited category of disadvantaged classes so recognized by our cases. Nor does the fact that the impact of the regulation falls upon those who cannot pay lead to a different conclusion. In a sense, every denial of welfare to an indigent creates a wealth classification as compared to nonindigents who are able to pay for the desired goods or services. But this Court has never held that financial need alone identifies a suspect class for purposes of equal protection analysis.
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> . . .

The remaining question then is whether the Hyde Amendment is rationally related to a legitimate governmental objective. It is the government's position that the Hyde Amendment bears a rational relationship to its legitimate interest in protecting the potential life of the fetus. We agree.

In [*Roe*], the Court recognized that the state has an "important and legitimate interest in protecting the potentiality of human life." That interest was found to exist throughout a pregnancy, [growing] "in substantiality as the woman approaches term." 410 U.S. 113, 163 (1973). See also *Beal v. Doe, supra.* Moreover, in *Maher, supra*, the Court held that Connecticut's decision to fund the costs associated with childbirth but not those associated with nontherapeutic abortions was a rational means of advancing the legitimate state interest in protecting potential life by encouraging childbirth. See also *Poelker v. Doe,* 432 U.S. 519 (1977).

It follows that the Hyde Amendment, by encouraging childbirth except in the most urgent circumstances, is rationally related to the legitimate governmental objective of protecting potential life. By subsidizing the medical expenses of indigent women who carry their pregnancies to term while not subsidizing the comparable expenses of women who undergo abortions (except those whose lives are threatened), Congress has

established incentives that make childbirth a more attractive alternative than abortion for persons eligible for Medicaid. These incentives bear a direct relationship to the legitimate congressional interest in protecting potential life. Nor is it irrational that Congress has authorized federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions. Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.

. . .

[III. Conclusion]

For the reasons stated in this opinion, we hold that a state that participates in the Medicaid program is not obligated under Title XIX to continue to fund those medically necessary abortions for which federal reimbursement is unavailable under the Hyde Amendment. We further hold that the funding restrictions of the Hyde Amendment violate neither the Fifth Amendment nor the Establishment Clause of the First Amendment. It is also our view that the appellees lack standing to raise a challenge to the Hyde Amendment under the Free Exercise Clause of the First Amendment. Accordingly, the judgment of the District Court is reversed, and the case is remanded to that court for further proceedings consistent with this opinion.

It is so ordered.

MOORE v. REGENTS OF THE UNIVERSITY OF CALIFORNIA

Supreme Court of California, 1990
793 P.2d 479

Panelli, Justice.

I. Introduction

We granted review in this case to determine whether plaintiff has stated a cause of action against his physician and other defendants for using his cells in potentially lucrative medical research without his permission. Plaintiff alleges that his physician failed to disclose preexisting research and economic interests in the cells before obtaining consent to the medical procedures by which they were extracted. . . . [The Superior Court agreed and the Court of Appeal reversed.]

II. Facts

Our only task [in this case] is to determine whether the complaint states a cause of action. . . .

The plaintiff is John Moore, who underwent treatment for hairy-cell leukemia at UCLA Medical Center. The five defendants are 1) Dr. David W. Golde, a physician who attended Moore at UCLA Medical Center; 2) the Regents of the University of California, who own and operate the university; 3) Shirley G. Quan, a researcher employed by the Regents; 4) Genetics Institute, Inc., and 5) Sandoz Pharmaceuticals Corporation. . . .

Moore first visited UCLA Medical Center on October 5, 1976, shortly after he learned that he had hairy-cell leukemia. After hospitalizing Moore and [withdrawing] "extensive amounts of blood, bone marrow aspirate, and other bodily substances," Golde confirmed that diagnosis. At this time, all defendants, including Golde, were aware that "certain blood products and blood components were of great value in a number of commercial and scientific efforts" and that access to a patient whose blood contained these substances would provide "competitive, commercial, and scientific advantages."

On October 8, 1976, Golde recommended that Moore's spleen be removed. . . . [Golde said] "that he had reason to fear for his [Moore's] life, and that the . . . operation . . . was necessary to slow down the progress of his disease." Based upon Golde's representations, Moore signed a written consent form authorizing the splenectomy.

Before the operation, Golde and Quan "formed the intent and made arrangements to obtain portions of [Moore's] spleen following its removal" and to take them to a separate research unit. Golde gave written instructions to this effect on October 18 and 19, 1976. These research activities "were not intended to have . . . any

relation to [Moore's] medical . . . care." However, neither Golde nor Quan informed Moore of their plans to conduct this research or requested his permission. Surgeons at UCLA Medical Center . . . removed Moore's spleen on October 20, 1976.

[From his home in Seattle,] Moore returned to the UCLA Medical Center several times between November 1976 and September 1983. He did so at Golde's direction and based upon representations "that such visits were necessary and required for his health and well-being . . . and based upon the trust inherent in and by virtue of the physician-patient relationship. . . ." On each of these visits, Golde withdrew additional samples of "blood, blood serum, skin, bone marrow aspirate, and sperm." . . .

"In fact, [however,] throughout the period of time that [Moore] was under [Golde's] care and treatment, . . . the defendants were actively involved in a number of activities which they concealed from [Moore]. . . ." Specifically, defendants were conducting research on Moore's cells and planned to "benefit financially and competitively . . . [by exploiting the cells] and [their] exclusive access to [the cells] by virtue of [Golde's] ongoing physician-patient relationship . . . ."

Sometime before August 1979, Golde established a cell line from Moore's T-lymphocytes.[31] On January 30, 1981, the Regents applied for a patent on the cell line, listing Golde and Quan as inventors. "[B]y virtue of an established policy . . ., [the] Regents, Golde, and Quan would share in any royalties or profits . . . arising out of [the] patent." The patent issued on March 20, 1984. . . .

With the Regents' assistance, Golde negotiated agreements for commercial development of the cell line and products to be derived from it. Under an agreement with Genetics Institute, Golde became a paid consultant and "acquired the rights to 75,000 shares of common stock." Genetics Institute also agreed to pay Golde and the Regents "at least $330,000 over three years, including a pro-rata share of [Golde's] salary and fringe benefits, in exchange for . . . exclusive access to the materials and research performed" on the cell line and products derived from it. On June 4, 1982,

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[31] A T-lymphocyte is a type of white blood cell. T-lymphocytes produce lymphokines, or proteins, that regulate the immune system. Some lymphokines have potential therapeutic value. If the genetic material responsible for producing a particular lymphokine can be identified, it can sometimes be used to manufacture large quantities of the lymphokine through the techniques of recombinant DNA.

While the genetic code for lymphokines does not vary from individual to individual, it can nevertheless be quite difficult to locate the gene responsible for a particular lymphokine. Because T-lymphocytes produce many different lymphokines, the relevant gene is often like a needle in a haystack. Moore's T-lymphocytes were interesting to the defendants because they overproduced certain lymphokines, thus making the corresponding genetic material easier to identify. . . .

Cells taken directly from the body (primary cells) are not very useful for these purposes. Primary cells typically reproduce a few times and then die. One can, however, sometimes continue to use cells for an extended period of time by developing them into a *cell line*, a culture capable of reproducing indefinitely. . . .

Sandoz "was added to the agreement," and compensation payable to Golde and the Regents was increased by $110,000. . . .

Based upon these allegations, Moore attempted to state 13 causes of action.[32] Each defendant demurred to [i.e., moved to dismiss,] each purported cause of action. The superior court, however, expressly considered the validity of only the first cause of action, conversion.[33] [but] . . . sustained a general demurrer, [i.e., a motion to dismiss]. . . . [The Court of Appeal reversed and directed the Superior Court to consider a number of other causes of action, as well as conversion.]

III. Discussion

A. Breach of Fiduciary Duty and Lack of Informed Consent

Moore repeatedly alleges that Golde failed to disclose the extent of his research and economic interests in Moore's cells before obtaining consent to the medical procedures by which the cells were extracted. These allegations . . . state a cause of action against Golde for invading a legally protected interest of his patient. This cause of action can properly be characterized either as the breach of a fiduciary duty to disclose facts material to the patient's consent or, alternatively, as the performance of medical procedures without first having obtained the patient's informed consent.

Our analysis begins with three well-established principles. First, "a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment." *Cobbs v. Grant,* 502 P.2d 1 (CA, 1972); *Schloendorff v. New York Hospital,* 105 N.E. 92 (NY, 1914). Second, "the patient's consent to treatment, to be effective, must be an informed consent." *Cobbs, supra.* Third, in soliciting the patient's consent, a physician has a fiduciary duty to disclose all information material to the patient's decision. *Cobbs, supra.*

These principles lead to the following conclusions: 1) a physician must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment; and 2) a physician's failure to disclose such interests may give rise to a cause of action for performing medical procedures without informed consent or breach of fiduciary duty.

To be sure, questions about the validity of a patient's consent to a procedure typically arise when the patient alleges that the physician failed to disclose medical

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[32] [Among them] were conversion, lack of informed consent, breach of fiduciary duty, fraud and deceit, unjust enrichment, quasi-contract, bad faith breach of the implied covenant of good faith and fair dealing, and intentional infliction of emotional distress.

[33] Added. *Conversion*, according to *Black's Law Dictionary*, is the "unauthorized assumption and exercise of the right of ownership over goods . . . belonging to another, to the alteration of their condition or the exclusion of the owner's rights."

risks, as in malpractice cases, and not when the patient alleges that the physician had a personal interest, as in this case. The concept of informed consent, however, is broad enough to encompass the latter. "The scope of the physician's communication to the patient . . . must be measured by the patient's need, and that need is whatever information is material to the decision." *Cobbs, supra.*

Indeed, the law already recognizes that a reasonable patient would want to know whether a physician has an economic interest that might affect the physician's professional judgment. As the Court of Appeal has said, "Certainly a sick patient deserves to be free of any reasonable suspicion that his doctor's judgment is influenced by a profit motive." *Magan Medical Clinic v. California State Board of Medical Examiners,* 57 Cal.Rptr. 256 (1967). The desire to protect patients from possible conflicts of interest has also motivated legislative enactments. Among these is [California] Business and Professions Code, §654.2. Under that section, a physician may not charge a patient on behalf of, or refer a patient to, any organization in which the physician has a "significant beneficial interest, unless [the physician] first discloses in writing to the patient that there is such an interest and advises the patient that the patient may choose any organization for the purposes of obtaining the services ordered or requested by [the physician]." Similarly, under [California] Health and Safety Code, §24173, a physician who plans to conduct a medical experiment on a patient must, among other things, inform the patient of "[t]he name of the sponsor or funding source, if any, . . . and the organization, if any, under whose general aegis the experiment is being conducted."

It is important to note that no law prohibits a physician from conducting research in the same area in which he practices. Progress in medicine often depends upon physicians, such as those practicing at the university hospital where Moore received treatment, who conduct research while caring for their patients.

. . . [A] physician who treats a patient in whom he also has a research interest has potentially conflicting loyalties. This is because medical treatment decisions are made on the basis of proportionality -- weighing the benefits *to the patient* against the risks *to the patient.* . . . A physician who adds his own research interests to this balance may be tempted to order a scientifically useful procedure or test that offers marginal, or no, benefits to the patient.[34] The possibility that an interest extraneous to the patient's health has affected the physician's judgment is something that a reasonable patient would want to know in deciding whether to consent to a proposed course of treatment. It is material to the patient's decision and, thus, a prerequisite to informed consent; *Cobbs, supra.*

Golde argues that the scientific use of cells that have already been removed cannot possibly affect the patient's medical interests. The argument is correct in one instance but not in another. If a physician has no plans to conduct research on a patient's

[34] Added. This is, in fact, precisely what Moore has alleged with respect to the postoperative withdrawals of blood and other substances.

cells at the time he recommends the medical procedure by which they are taken, then the patient's medical interests have not been impaired. In that instance, the argument is correct. On the other hand, a physician who does have a preexisting research interest might, consciously or unconsciously, take that into consideration in recommending the procedure. In that instance, the argument is incorrect: the physician's extraneous motivation may affect his judgment and is, thus, material to the patient's consent.

We acknowledge that there is a competing consideration. To require disclosure of research and economic interests may corrupt the patient's own judgment by distracting him from the requirements of his health. But California law does not grant physicians unlimited discretion to decide what to disclose. Instead, "it is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie." *Cobbs, supra.*

Accordingly, we hold that a physician who is seeking a patient's consent for a medical procedure must, in order to satisfy his fiduciary duty and to obtain the patient's informed consent, disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his medical judgment.

1. Dr. Golde

. . .

. . . Moore alleges that, prior to the surgical removal of his spleen, Golde "formed the intent and made arrangements to obtain portions of his spleen following its removal from [Moore] in connection with [his] desire to have regular and continuous access to, and possession of, [Moore's] unique and rare blood and bodily substances." Moore was never informed, prior to the splenectomy, of Golde's *prior formed intent* to obtain a portion of his spleen. In our view, these allegations adequately show that Golde had an undisclosed research interest in Moore's cells at the time he sought Moore's consent to the splenectomy. Accordingly, Moore has stated a cause of action for breach of fiduciary duty, or lack of informed consent, based upon the disclosures accompanying that medical procedure.

We next discuss the adequacy of Golde's alleged disclosures regarding the postoperative takings of blood and other samples. In this context, Moore alleges that Golde "expressly, affirmatively, and impliedly represented . . . that these withdrawals of his blood and bodily substances were necessary and required for his health and well-being." However, Moore also alleges that Golde actively concealed his economic interest in Moore's cells during this time period. . . . "[D]uring each of these visits . . . , and even when [Moore] inquired as to whether there was any possible or potential commercial or financial value or significance to his blood and bodily substances, or whether the defendants had discovered anything . . . which was or might be . . . related to any scientific activity resulting in commercial or financial benefits . . . , the defendants repeatedly and affirmatively represented to [Moore] that there was no commercial or

financial value to his blood and bodily substances . . . and in fact actively discouraged such inquiries."

Moore admits in his complaint that defendants disclosed they "were engaged in strictly academic and purely scientific medical research. . . ." However, Golde's representation that he had no financial interest in this research became false, . . . at least by May 1979, when he "began to investigate and initiate the procedures . . . for [obtaining] a patent" on the cell line developed from Moore's cells.

. . . Therefore, . . . the allegations state a cause of action for breach of fiduciary duty or lack of informed consent.

. . .

2. The Remaining Defendants

The Regents, Quan, Genetics Institute, and Sandoz are not physicians. In contrast to Golde, none of these defendants stood in a fiduciary relationship with Moore or had the duty to obtain Moore's informed consent to medical procedures. If any of these defendants is to be liable for breach of fiduciary duty or performing medical procedures without informed consent, it can only be on account of Golde's acts and on the basis of a recognized theory of [vicarious] liability, such as *respondeat superior*.[35] . .

B. Conversion

Moore also attempts to characterize the invasion of his rights as a conversion -- a tort that protects against interference with possessory and ownership interests in personal property. He theorizes that he continued to own his cells following their removal from his body, at least for the purpose of directing their use, and that he never consented to their use in potentially lucrative medical research. Thus, . . . [Moore argues the] unauthorized use of his cells constitutes a conversion. As a result of the alleged conversion, Moore claims a proprietary interest in each of the products that any of the defendants might ever create from his cells or the patented cell line.

No court, however, has ever in a reported decision imposed conversion liability for the use of human cells in medical research. While that fact does not end our inquiry, it raises a flag of caution. In effect, what Moore is asking us to do is to impose a tort duty on scientists to investigate the consensual pedigree of each human cell sample used in research. To impose such a duty, which would affect medical research of importance

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[35] Added. This Latin phrase means "let the master answer"; the doctrine permits a master/principle/employer to be held liable for the negligent, in-scope torts of his servant./agent/employee. *Health Law for Federal Sector Administrators*, Glossary, Karin Waugh Zucker and Martin J. Boyle, eds. (not formally published; printed by the Army Medical Department and School, 8th ed., 2000).

to all of society, implicates policy concerns far removed from the traditional, two-party ownership disputes in which the law of conversion arose. . . .

. . .

1. Moore's Claim Under Existing Law

"To establish a conversion, plaintiff must establish an actual interference with his *ownership* or *right of possession*. . . . Where plaintiff neither has title to the property alleged to have been converted, nor possession thereof, he cannot maintain an action for conversion." *General Motors A. Corp. v. Dallas,* 245 P. 184 (CA, 1926).

Since Moore clearly did not expect to retain possession of his cells following their removal, to [successfully] sue for their conversion he must have retained an ownership interest in them. But there are several reasons to doubt that he did retain any such interest. . . . First, no reported judicial decision supports Moore's claim, either directly or by close analogy. Second, California statutory law drastically limits any continuing interest of a patient in excised cells. Third, the subject matters of the Regents' patent -- the patented cell line and the products derived from it -- cannot be Moore's property.

. . .

Lacking direct authority for importing the law of conversion into this context, Moore relies, as did the Court of Appeal, primarily on decisions addressing privacy rights.[36] One line of cases involves unwanted publicity. *Lugosi v. Universal Pictures,* 603 P.2d 425 (CA, 1979); *Motschenbacher v. R. J. Reynolds Tobacco Company,* 498 F.2d 821 (1974), [interpreting California law]. These opinions hold that every person has a proprietary interest in his own likeness and that unauthorized, business use of a likeness is redressible as a tort. But in neither opinion did the authoring court expressly base its holding on property law. Each court stated, following Prosser, [the famous tort law professor], that it was pointless to debate the proper characterization of the proprietary interest in a likeness. For purposes of determining whether the tort of conversion lies, however, the characterization of the right in question is far from pointless. Only property can be converted.

Not only are the wrongful publicity cases irrelevant to the issue of conversion, but the analogy to them seriously misconceives the nature of the genetic materials and research involved in this case. Moore . . . argues that "[i]f the courts have found a sufficient proprietary interest in one's persona, how could one not have a right in one's

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[36] No party has cited a decision supporting Moore's argument that excised cells are "a species of tangible personal property capable of being converted." On this point the Court of Appeal cited only *Venner v. State,* 354 A.2d 483 (MD, 1976), which dealt with the seizure of a criminal defendant's feces from a hospital bedpan by police officers searching for narcotics. The court held that, for purposes of the Fourth Amendment, the defendant had abandoned his excrement. . . . [The opinion was one of criminal law] grounded in markedly different policies and has little relevance to the case before us.

own genetic material, something far more profoundly the essence of one's human uniqueness than a name or a face?" However, as the defendants' patent makes clear . . . the goal and result of defendants' efforts has been to manufacture lymphokines. Lymphokines, unlike a name or a face, have the same molecular structure in every human being and the same, important functions in every human being's immune system. Moreover, the particular genetic material which is responsible for the natural production of lymphokines, and which defendants use to manufacture lymphokines in the laboratory, is also the same in every person; it is no more unique to Moore than the number of vertebrae in the spine or the chemical formula of hemoglobin.

Another privacy case offered by analogy to support Moore's claim establishes only that patients have a right to refuse medical treatment. *Bouvia v. Superior Court,* 225 Cal.Rptr. 297 (1986). In this context, the court in *Bouvia* wrote that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ", quoting from *Schloendorff, supra. Re*lying on this language to support the proposition that a patient has a continuing right to control the use of excised cells, the Court of Appeal in this case concluded that "[a] patient must have the ultimate power to control what becomes of his or her tissues. To hold otherwise would open the door to a massive invasion of human privacy and dignity in the name of medical progress." Yet one may earnestly wish to protect privacy and dignity without accepting the extremely problematic conclusion that interference with those interests amounts to a conversion of personal property. Nor is it necessary to force the round pegs of *privacy* and *dignity* into the square hole of *property* in order to protect the patient, since the fiduciary-duty and informed-consent theories protect these interests directly by requiring full disclosure.

The next consideration that makes Moore's claim of ownership problematic is California statutory law, which drastically limits a patient's control over excised cells.

> Notwithstanding any other provision of law, recognizable anatomical parts, human tissues, anatomical human remains, or infectious waste following conclusion of scientific use shall be disposed of by interment, incineration, or any other method determined by the state department [of health services] to protect the public health and safety. [California] Health and Safety Code, §7054.4

Clearly, the legislature did not specifically intend this statute to resolve the question of whether a patient is entitled to compensation for the nonconsensual use of excised cells. A primary object of the statute is to ensure the safe handling of potentially hazardous biological waste materials. Yet, one cannot escape the conclusion that the statute's practical effect is to limit, drastically, a patient's control over excised cells. By restricting how excised cells may be used and requiring their eventual destruction, the statute eliminates so many of the rights ordinarily attached to property that one cannot simply assume that what is left amounts to *property* or *ownership* for purposes of conversion law.

It may be that some limited right to control the use of excised cells does survive the operation of this statute. There is, for example, no need to read the statute to permit *scientific use* contrary to the patient's expressed wish. A fully informed patient may always withhold consent to treatment by a physician whose research plans the patient does not approve. That right, however, as already discussed, is protected by the fiduciary-duty and informed consent theories.

Finally, the subject matter of the Regents' patent -- the patented cell line and the products derived from it -- cannot be Moore's property. This is because the patented cell line is both factually and legally distinct from the cells taken from Moore's body.[37] Federal law permits the patenting of organisms that represent the product of *human ingenuity*, but not naturally occurring organisms. *Diamond v. Chakrabarty,* 447 U.S. 303 (1980). Human cell lines are patentable because "[l]ong-term adaptation and growth of human tissues and cells in culture is difficult. . . ," and the probability of success is low. (Office of Technology Assessment Report, *New Developments in Biotechnology: Ownership of Human Tissues and Cells* (1987)). It is this *inventive effort* that patent law rewards, not the discovery of naturally occurring raw materials. Thus, Moore's allegations that he owns the cell line and the products derived from it are inconsistent with the patent, which constitutes an authoritative determination that the cell line is the product of invention.

2. Should Conversion Liability Be Extended?

. . .

There are three reasons why it is inappropriate to impose liability for conversion based upon the allegations of Moore's complaint. First, a fair balancing of the relevant policy considerations counsels against extending the tort. Second, problems in this area are better suited to legislative resolution. Third, the tort of conversion is not necessary to protect patients' rights. For these reasons, we conclude that the use of excised human cells in medical research does not amount to a conversion.

Of the relevant policy considerations, two are of overriding importance. The first is protection of a competent patient's right to make autonomous medical decisions. That right, as already discussed, is grounded in well-recognized and long-standing principles of fiduciary duty and informed consent. This policy weighs in favor of providing a remedy to patients when physicians act with undisclosed motives that may

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[37] The distinction between primary cells (cells taken directly from the body) and patented cell lines is not purely a legal one. Cells change while being developed into a cell line and continue to change over time. OTA Rep., *supra.* "[I]t is clear that most established cell lines . . . are not completely normal. Besides [an] enhanced growth potential relative to primary cells, they frequently have highly abnormal chromosome numbers . . . ." 2 Watson et al., *Molecular Biology of the Gene* (4th ed. 1987) p. 967.

The cell line in this case, for example, after many replications, began to generate defective and rearranged forms of the HTLV-II virus. A published research paper to which defendants contributed suggests that "the defective forms of virus were probably generated during the passage [or replication] of the cells rather than being present in the original tumor cells of the patient. . . ."

affect their professional judgment. The second important policy consideration is that we not threaten with disabling civil liability innocent parties who are engaged in socially useful activities, such as researchers who have no reason to believe that their use of a particular cell sample is, or may be, against a donor's wishes.

. . .

We need not, however, make an arbitrary choice between liability and nonliability. Instead, an examination of the relevant policy considerations suggests an appropriate balance: Liability based upon existing disclosure obligations, rather than an unprecedented extension of the conversion theory, protects patients' rights of privacy and autonomy without unnecessarily hindering research.

Research on human cells plays a critical role in medical research . . . because researchers are increasingly able to isolate naturally occurring, medically useful biological substances and to produce useful quantities of such substances through genetic engineering. These efforts are beginning to bear fruit. Products developed through biotechnology that have already been approved for marketing in this country include treatments and tests for leukemia, cancer, diabetes, dwarfism, hepatitis-B, kidney transplant rejection, emphysema, osteoporosis, ulcers, anemia, infertility, and gynecological tumors, to name but a few.

The extension of conversion law into this area will hinder research by restricting access to the necessary raw materials. Thousands of human cell lines already exist in tissue repositories, such as the American Type Culture Collection and those operated by the National Institutes of Health and the American Cancer Society. These repositories respond to tens of thousands of requests for samples annually. Since the patent office requires the holders of patents on cell lines to make samples available to anyone, many patent holders place their cell lines in repositories to avoid the administrative burden of responding to requests. At present, human cell lines are routinely copied and distributed to other researchers for experimental purposes, usually free of charge. This exchange of scientific materials, which still is relatively free and efficient, will surely be compromised if each cell sample becomes the potential subject matter of a lawsuit. Office of Technology Assessment Report, *supra.*

To expand liability by extending conversion law into this area would have a broad impact. The House Committee on Science and Technology of the United States Congress found that "49% of the researchers at medical institutions surveyed used human tissues or cells in their research." Many receive grants from the National Institute of Health for this work. In addition, "there are nearly 350 commercial biotechnology firms in the United States actively engaged in biotechnology research and commercial product development and approximately 25 to 30% appear to be engaged in research to develop a human therapeutic or diagnostic reagent. . . . Most, but not all, of the human therapeutic products are derived from human tissues and cells, or human cell lines or cloned genes." Office of Technology Assessment Report, *supra.*

In deciding whether to create new tort duties we have in the past considered the impact that expanded liability would have on activities that are important to society, such as research. For example, in *Brown v. Superior Court,* 44 Cal.3d 1049 (1988), the fear that strict product liability would frustrate pharmaceutical research led us to hold that a drug manufacturer's liability should not be measured by those standards. We wrote that, "[I]f drug manufacturers were subject to strict liability, they might be reluctant to undertake research programs to develop some pharmaceuticals that would prove beneficial or to distribute others that are available to be marketed, because of the fear of large adverse monetary judgments."

As in *Brown, supra,* the theory of liability that Moore urges us to endorse threatens to destroy the economic incentive to conduct important medical research. If the use of cells in research is a conversion, then with every cell sample a researcher purchases a ticket in a litigation lottery. Because liability for conversion is predicated on a continuing ownership interest, "companies are unlikely to invest heavily in developing, manufacturing, or marketing a product when uncertainty about clear title exists." Office of Technology Assessment Report, *supra.* In our view, borrowing again from *Brown,* "[i]t is not unreasonable to conclude in these circumstances that the imposition of a harsher test for liability would not further the public interest in the development and availability of these important products."

. . .

. . . If the scientific users of human cells are to be held liable for failing to investigate the consensual pedigree of their raw materials, we believe the Legislature should make that decision. Complex policy choices affecting all society are involved, and "legislatures in making such policy decisions, have the ability to gather empirical evidence, solicit the advice of experts, and hold hearings at which all interested parties present evidence and express their views. . . . " *Foley v. Interactive Data Corp.,* 47 Cal. 3d 654 (1988). . . .

. . .

For these reasons, we hold that the [Moore's] allegations . . . state a cause of action for breach of fiduciary duty or lack of informed consent, but not conversion. . . .

PARKER v. LEVY

U.S. Supreme Court, 1974
417 U.S. 733

Mr. Justice Renquist delivered the opinion of the Court.[38]

Appellee Howard Levy, a physician, was a captain in the Army stationed at Fort Jackson, South Carolina. He had entered the Army under the so-called *Berry Plan*, 50 U.S.C. App. 454 (j), under which he agreed to serve for two years in the Armed Forces if permitted first to complete his medical training. From the time he entered on active duty in July 1965 until his trial by court-martial, he was assigned as Chief of the Dermatological Service of the United States Army Hospital at Fort Jackson. On June 2, 1967, appellee was convicted by a general court-martial of violations of Articles 90, 133, and 134 of the Uniform Code of Military Justice, and sentenced to dismissal from the service, forfeiture of all pay and allowances, and confinement for three years at hard labor.

The facts upon which his conviction rests are virtually undisputed. The evidence admitted at his court-martial showed that one of the functions of the hospital to which appellee was assigned was that of training Special Forces aide men. As Chief of the Dermatological Service, appellee was to conduct a clinic for those aide men. In the late summer of 1966, it came to the attention of the hospital commander that the dermatology training of the students was unsatisfactory. After investigating the program and determining that appellee had totally neglected his duties, the commander called appellee to his office and personally handed him a written order to conduct the training. Appellee read the order, said that he understood it, but declared that he would not obey it because of his medical ethics. Appellee persisted in his refusal to obey the order, and later reviews of the program established that the training was still not being carried out.

During the same period of time, appellee made several public statements to enlisted personnel at the post, of which the following is representative:

> The United States is wrong in being involved in the Viet Nam War. I would refuse to go to Viet Nam if ordered to do so. I don't see why any colored soldier would go to Viet Nam: they should refuse to go to Viet Nam and if sent should refuse to fight because they are discriminated against and denied their freedom in the United States, and they are sacrificed and discriminated against in Viet Nam by being given all the

[38] Added from the body of the case. . . . Chief Justice Burger and Justices White, Blackmun, and Powell joined in Justice Rehnquist's opinion. Justice Blackmun filed a concurring statement in which Chief Justice Burger joined. . . . Justice Douglas filed a dissenting opinion. Justice Steward filed a dissenting opinion, in which Justices Douglas and Brennan joined. Justice Marshall took no part in the consideration or decision of the case.

> hazardous duty and they are suffering the majority of casualties. If I were a colored soldier I would refuse to go to Viet Nam and if I were a colored soldier and were sent I would refuse to fight. Special Forces personnel are liars and thieves and killers of peasants and murderers of women and children.

Appellee's military superiors originally contemplated nonjudicial proceedings against him under Article 15 of the Uniform Code of Military Justice, 10 U.S.C. §815, but later determined that court-martial proceedings were appropriate. The specification under Article 90 alleged that appellee willfully disobeyed the hospital commandant's order to establish the training program, in violation of that article, which punishes anyone subject to the Uniform Code of Military Justice who "willfully disobeys a lawful command of his superior commissioned officer." Statements to enlisted personnel were listed as specifications under the charges of violating Articles. 133[39] and 134[40] of the Code. . . .

The specification under Article 134 alleged that appellee "did, at Fort Jackson, South Carolina, . . . with design to promote disloyalty and disaffection among the troops, publicly utter certain statements to divers enlisted personnel at divers times . . . ." The specification under Article 133 alleged that appellee did "while in the performance of his duties at the United States Army Hospital . . . wrongfully and dishonorably" make statements variously described as intemperate, defamatory, provoking, disloyal, contemptuous, and disrespectful to Special Forces personnel and to enlisted personnel who were patients or under his supervision.

Appellee was convicted by the court-martial, and his conviction was sustained on his appeals within the military. After he had exhausted this avenue of relief, he sought federal *habeas corpus*[41] . . . challenging his court-martial conviction on a number of grounds. The District Court . . . denied relief. It held that the "various articles of the Uniform Code of Military Justice are not unconstitutional for vagueness,"

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[39] Article 133 of the Uniform Code of Military Justice, 10 U.S.C. §933, provides:

> Any commissioned officer, cadet, or midshipman who is convicted of conduct unbecoming an officer and a gentleman shall be punished as a court-martial may direct.

[40] Article 134 of the Uniform Code of Military Justice, 10 U.S.C. §934, provides:

> Though not specifically mentioned in this chapter, all disorders and neglects to the prejudice of good order and discipline in the armed forces, all conduct of a nature to bring discredit upon the armed forces, and crimes and offenses not capital, of which persons subject to this chapter may be guilty, shall be taken cognizance of by a general, special, or summary court-martial, according to the nature and degree of the offense, and shall be punished at the discretion of that court.

[41] Added. This Latin phrase, *habeas corpus*, means "you have the body"; the writ directs a person detaining another to bring him before, i.e., into the jurisdiction of, the court, in this case a U.S. District Court, in the hope that that court would then release him from custody.

citing several decisions of the United States Court of Military Appeals.[42] The court rejected the balance of appellee's claims without addressing them individually, noting that the military tribunals had given fair consideration to them and that the role of the federal courts in reviewing court-martial proceedings was a limited one.

The Court of Appeals reversed (478 F.2d 772 (CA, 1973)) holding in a lengthy opinion that Arts. 133 and 134 are void for vagueness. The court found little difficulty in concluding that "as measured by contemporary standards of vagueness applicable to statutes and ordinances governing civilians," the general articles "do not pass constitutional muster. "It relied on such cases as *Grayned v. City of Rockford*, 408 U.S. 104 (1972); *Papachristou v. City of Jacksonville*, 405 U.S. 156 (1972); *Giaccio v. Pennsylvania*, 382 U.S. 399 (1966); *Coates v. City of Cincinnati*, 402 U.S. 611 (1971); and *Gelling v. Texas*, 343 U.S. 960 (1952). . . .

Appellants appealed to this Court pursuant to 28 U.S.C. §1252. . . .

I. [History of the Military as a Separate Society]

This Court has long recognized that the military is, by necessity, a specialized society separate from civilian society. We have also recognized that the military has, again by necessity, developed laws and traditions of its own during its long history. The differences between the military and civilian communities result from the fact that "it is the primary business of armies and navies to fight or be ready to fight wars should the occasion arise." *United States ex rel. Toth v. Quarles*, 350 U.S. 11, 17 (1955). In *In re Grimley*, 137 U.S. 147, 153 (1890), the Court observed: "An army is not a deliberative body. It is the executive arm. Its law is that of obedience. No question can be left open as to the right to command in the officer, or the duty of obedience in the soldier." More recently we noted that "[t]he military constitutes a specialized community governed by a separate discipline from that of the civilian," *Orloff v. Willoughby*, 345 U.S. 83, 94 (1953), and that "the rights of men in the armed forces must perforce be conditioned to meet certain overriding demands of discipline and duty . . . ." *Burns v. Wilson*, 346 U.S. 137, 140 (1953). We have also recognized that a military officer holds a particular position of responsibility and command in the Armed Forces:

> The President's commission . . . recites that `reposing special trust and confidence in the patriotism, valor, fidelity and abilities' of the appointee he is named to the specified rank during the pleasure of the President. *Orloff v. Willoughby, supra*, at 91.

Just as military society has been a society apart from civilian society, so "[m]ilitary law . . . is a jurisprudence which exists separate and apart from the law which governs in our federal judicial establishment." *Burns v. Wilson, supra*, at 140. And to maintain the discipline essential to perform its mission effectively, the military

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[42] Added. The name of this court has been changed; it is now the U.S. Court of Appeals for the Armed Services.

has developed what "may not unfitly be called the customary military law" or "general usage of the military service." *Martin v. Mott*, 12 Wheat. 19, 35 (1827). . . .[This] Court has approved the enforcement of those military customs and usages by courts-martial from the early days of this nation.

. . .

An examination of the British antecedents of our military law shows that the military law of Britain had long contained the forebears of Articles 133 and 134 in remarkably similar language. The Articles of the Earl of Essex (1642) provided that "[a]ll other faults, disorders and offenses, not mentioned in these Articles, shall be punished according to the general customs and laws of war." One of the British Articles of War of 1765 made punishable "all Disorders or Neglects . . . to the Prejudice of good Order and Military Discipline . . ." that were not mentioned in the other articles. . . .

. . .

Decisions of this Court during the last century have recognized that the longstanding customs and usages of the services impart accepted meaning to the seemingly imprecise standards of Articles 133 and 134. In *Dynes v. Hoover*, 20 How. 65 (1857), this Court upheld the Navy's general article, which provided that "[a]ll crimes committed by persons belonging to the navy, which are not specified in the foregoing articles, shall be punished according to the laws and customs in such cases at sea.". . .

. . .

In *United States v. Fletcher*, 148 U.S. 84 (1893), the Court considered a court-martial conviction under what is now Article 133, rejecting Captain Fletcher's claim that the court-martial could not properly have held that his refusal to pay a just debt was "conduct unbecoming an officer and a gentleman." The Court of Claims decision which the Court affirmed in Fletcher stressed the military's "higher code termed honor, which holds its society to stricter accountability" and with which those trained only in civilian law are unfamiliar. . . .

The Court of Claims had observed that cases involving "conduct to the prejudice of good order and military discipline," as opposed to conduct unbecoming an officer, "are still further beyond the bounds of ordinary judicial judgment, for they are not measurable by our innate sense of right and wrong, of honor and dishonor, but must be gauged by an actual knowledge and experience of military life, its usages and duties." *Swaim v. United States*, 28 Ct. Cl. 173, 228 (1893).

II. [Military and Civilian Law Differ]

The differences noted by this settled line of authority, first between the military community and the civilian community, and second between military law and civilian law, continue in the present day under the Uniform Code of Military Justice. That Code cannot be equated to a civilian criminal code. It, and the various versions of the Articles of War which have preceded it, regulate aspects of the conduct of members of the military which in the civilian sphere are left unregulated. . . .

. . .

In short, the Uniform Code of Military Justice regulates a far broader range of the conduct of military personnel than a typical state criminal code regulates of the conduct of civilians. . . .

The availability of these lesser sanctions is not surprising in view of the different relationship of the government to members of the military. It is not only that of lawgiver to citizen, but also that of employer to employee. Indeed, unlike the civilian situation, the government is often employer, landlord, provisioner, and lawgiver rolled into one. That relationship also reflects the different purposes of the two communities. As we observed in *In re Grimley,* 137 U.S. 147 (1890), the military is the executive arm whose law is that of obedience. While members of the military community enjoy many of the same rights and bear many of the same burdens as do members of the civilian community, within the military community there is simply not the same autonomy as there is in the larger civilian community. . . .

. . .

With these very significant differences between military law and civilian law and between the military community and the civilian community in mind, we turn to appellee's challenges to the constitutionality of Articles 133 and 134.

III. [Discussion]

. . .

The Court of Military Appeals has . . . limited the scope of Article 133. Quoting from W. Winthrop, *Military Law and Precedents* 711-712 (2d ed. 1920), that court has stated:

> To constitute therefore the conduct here denounced, the act which forms the basis of the charge must have a double significance and effect. Though it need not amount to a crime, it must offend so seriously against law, justice, morality or decorum as to expose to disgrace, socially or as a man, the offender, and at the same time must be of such a nature or committed under such circumstances as to bring dishonor or disrepute

upon the military profession which he represents. *United States v. Howe*, 37 C. M. R. 429, 441-442 (1967).

The effect of these constructions of Articles 133 and 134 by the Court of Military Appeals and by other military authorities has been twofold: It has narrowed the very broad reach of the literal language of the articles, and at the same time has supplied considerable specificity by way of examples of the conduct which they cover. . . .

. . .

While the members of the military are not excluded from the protection granted by the First Amendment, the different character of the military community and of the military mission requires a different application of those protections. The fundamental necessity for obedience, and the consequent necessity for imposition of discipline, may render permissible within the military that which would be constitutionally impermissible outside it. . . . The United States Court of Military Appeals has sensibly expounded the reason for this different application of First Amendment doctrines in its opinion in *United States v. Priest*, 45 C. M. R., at 344:

> In the armed forces some restrictions exist for reasons that have no counterpart in the civilian community. Disrespectful and contemptuous speech, even advocacy of violent change, is tolerable in the civilian community, for it does not directly affect the capacity of the government to discharge its responsibilities unless it both is directed to inciting imminent lawless action and is likely to produce such action. *Brandenburg v. Ohio*, 395 U.S. 444 (1969). In military life, however, other considerations must be weighed. The armed forces depend on a command structure that at times must commit men to combat, not only hazarding their lives but ultimately involving the security of the nation itself. Speech that is protected in the civil population may nonetheless undermine the effectiveness of response to command. If it does, it is constitutionally unprotected. *United States v. Gray*, 42 C. M. R. 255 (1970).

. . .

There is a wide range of conduct of military personnel to which Articles 133 and 134 may be applied without infringement of the First Amendment. While there may lurk at the fringes of the articles, even in the light of their narrowing construction by the United States Court of Military Appeals, some possibility that conduct which would be ultimately held to be protected by the First Amendment could be included within their prohibition, we deem this insufficient to invalidate either of them at the behest of appellee. His conduct, that of a commissioned officer publicly urging enlisted personnel to refuse to obey orders which might send them into combat, was unprotected under the most expansive notions of the First Amendment. Articles 133 and 134 may

constitutionally prohibit that conduct, and a sufficiently large number of similar or related types of conduct so as to preclude their invalidation for overbreadth.

IV. [Conclusion]

Appellee urges that should we disagree with the Court of Appeals as to the constitutionality of Arts. 133 and 134, we should nonetheless affirm its judgment by invalidating his conviction under Art. 90. . . .

. . .

Reversed.

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF ALABAMA NORTHERN DIVISION

CHARLIE W. POLLARD, LESTER M. SCOTT, HERMAN SHAW, CARTER HOWARD, EARLY BANKS, LEARNIE BERRY, PUSTELL BLEDSOE, LOGAN BROWN, POLLARD CHAMBLISS, JIM COLLINS, MARTIN DAVIS, NAT DAVIS, ARCHIE FOSTER, LEE FOSTER, CHARLIER GRIGGS, WILLIAM PEDRO GRIGGS, EMMITT GRIMES, PERCY GRIMES, WALTER HARVEY, ERNEST HENDON, LOUIE B. HENDON, ISIAH JACKSON, JESSYE MADDOX, FONZY MAHONE, RICHARD MIMS, FELIX MOORE, WILLIE BILL MOORE, STEVE PACE, FLETCHER REED, ALBERT ROBINSON, NELSON SCOTT, FRED SIMMONS, DUDLEY SMITH, JOHN SMITH, JUDGE STORY, MILLARD STORY, MARK SWANSON, WARREN TAYLOR, PETER THOMPSON, BILL JESSIE WILLIAMS, BOOKER T. YANCEY, and all others the same or similarly situated

AND

ELVIRA S. BEASLEY, PRINCIE BLACK, ETHEL LEE RUSSELL BOWEN, WILLIE C. CASTON, LULA CHAPPEL, LEOLA VEAL COX, ALMA DANIEL, LESSIE B. DANIEL, GEORGIA DANIEL, LUCY DAVIS, FANNIE LOU DAWKINS, ANNIE RUTH JACKSON DILL, THOMAS DONER, WILLIE LOUISE FIELDS, CARRIE FOOTE, MARY BELL FOSTER, ADA GERMANY, MATTIE GERMANY, NAOMI GERMANY, ANNIE MAY GRIFFIN, MARY EMMA HALL, SALLIE HARRIS, SILVIA HARVEY, BETTY HUGHLEY, ELIZABETH JACKSON, NATHANIEL JACKSON, MOZELLE JAMES, MARY KEY, VIOLA MAHONE, FLORENCE MASON, CARRIE MOORE, LORINE PORCH OWENS, MARY LOU PACE, DAISY PEARSON, COLLINS A. PINKARD, PINKIE PINKARD, JESSIE MAE RENFROE,

FILED

JUL 24 1973

Jane P. Gordon, Clerk

By M.T.
Deputy Clerk

CIVIL ACTION NO. 4126-N

FANNIE M. SHAW, CARRIE STORY, LUCILLE KELLEY TORBERT, CLARA MAE POTTS TRAVIS, LEILA WEST, SUSANNNE WHITLOW, LUELLA WILLIS, And all other the same or similarly situated)

AND)

PRINCIE BLACK as Administratrix of the Estate of RUFFUS N. NEAL, Deceased and all others the same or similarly situated.)

PLAINTIFFS)

-VS-)

THE UNITED STATES OF AMERICA; THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE; THE UNITED STATES PUBLIC HEALTH SERVICE; THE UNITED STATES CENTER FOR DISEASE CONTROL, Venereal Disease Branch; THE MILBANK MEMORIAL FUND, a Corporation; THE STATE OF ALABAMA; THE STATE BOARD OF HEALTH, (Alabama))

AND)

CASPAR WEINBERGER as Secretary of the DEPARTMENT OF HEALTH, EDUCATION AND WELFARE; DR. IRA L. MEYERS, STATE HEALTH OFFICER (Alabama); DR. CHARLES C. EDWARDS, as Administrator for THE UNITED STATES PUBLIC HEALTH SERVICE; DR. J.D. MILLAR, as Chief of THE CENTER FOR DISEASE CONTROL, Venereal Disease Branch, DR. DONALD PRINTZ, as Assistant Chief, CENTER FOR DISEASE CONTROL, Venereal Disease Branch; and their successors in office,)

AND)

DR. JOHN R. HELLER, individually; DR. SIDNEY OLANSKY, individually; and DR. JOHN DOE individually, and DRS. A through Z, whose names)

are otherwise unknown but will be inserted when ascertained, each individually; and all others the same or similarly situated.)

DEFENDANTS.)

COMPLAINT

I. Jurisdiction

1. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. Sections 1331 (a) and U.S.C. 1343(3) and (4), 42 U.S.C. 1983 and the Fifth, Ninth, Thirteenth and Fourteenth Amendments to the Constitution of the United States.

2. This action also arises under the Federal Tort Claims Act, Act of June 25, 1948, 62 stat. 982, 28 U.S.C. Sections 1346(b), 2671 *et seq.,* as hereinafter more fully appears.

3. The jurisdiction of this Court is also invoked pursuant to Rule 23, Sections (a), (b)(1), (b)(2) and (b)(3) of the Federal Rules of Civil Procedure over the classes more specifically stated in Section II of this Complaint.

4. Jurisdiction of this Court is also invoked as to claims arising solely under the Laws of the State of Alabama, which claims involved are based upon the same facts, circumstances and instances upon which the federal claims referred to in this Complaint are based.

5. The matter in controversy exceeds the sum or value of TEN THOUSAND AND NO/100 ($10,000.00) Dollars, exclusive of interest and costs.

II. Parties

1. Plaintiffs.

a. Plaintiffs, Charlie W. Pollard, Lester M. Scott, Herman Shaw, Carter Howard, Early Banks, Learnie Berry, Pustell Bledsoe, Lagan Brown, Pollard Chambliss, Jim Collins, Martin Davis, Nat Dennis, Archie Foster, Lee Foster, Charlie Griggs, William Pedro Griggs, Emmitt Grimes, Percy Grimes, Walter Harvey, Ernest Hendon, Louie C. Hendon, Isiah Jackson, Jessye Maddox, Fonzy Mahone, Richard Mims, Felix Moore, Willie Bill Moore, Steve Pace, Fletcher Reed, Albert Robinson, Nelson Scott, Fred Simmons, Dudley Smith, John Smith, Judge Story, Millard Story, Mark Swanson, Warren Taylor, Peter Thompson, Bill Jessie Williams, Booker T. Yancey, and all others the same or

similarly situated, are persons over the age of 21 years, are citizens of the United States of America and belong to the Race of persons called Negro. Each Plaintiff is a participant and victim of what has now become known as the "Tuskegee Syphilis Study" and which will be more particularly described below.

Said Plaintiffs sue on their behalf and on behalf of all other subject participants of said Tuskegee Syphilis Study.

Said Plaintiffs above described will herein after be referred to collectively as Plaintiff-Subjects.

b. Plaintiffs, Elvira S. Beasley, Princie Black, Ethel Lee Russell Bowen, Willie C. Caston, Lula Chappel, Leola Veal Cox, Alma Daniel, Lessie B. Daniel, Georgia Daniel, Lucy Davis, Fannie Lou Dawkins, Annie Ruth Jackson Dill, Thomas Donor, Willie Louise Fields, Carrie Foote, Mary Bell Foster, Ada Germany, Mattie Germany, Naomi Germany, Annie Mae Griffin, Mary Emma Hall, Sallie Harris, Silvia Harvey, Betty Hughley, Elizabeth Jackson, Nathaniel Jackson, Mozelle James, Mary Key, Viola Mahone, Florence Mason, Carrie Moore, Lorine Porch Owens, Mary Lou Pace, Daisy Pearson, Collins A. Pinkard, Pinkie Pinkard, Jessie Mae Renfroe, Fannie M. Shaw, Carrie Story, Lucille Kelley Torbert, Clara Mae Potts Travis, Leila West, Susanna Whitlow, Louella Willis, and all other the same or similarly situated, are persons over the age of 21 years, citizens of the United States of America and belong to the Race of persons called Negro. Each of said Plaintiffs is a living heir of deceased patients and victims of what has now become known as the "Tuskegee Syphilis Study" and which will be more particularly described below. Said Plaintiffs sue on behalf of themselves and on behalf of the deceased subjects and victims of the said Tuskegee Syphilis Study. Said Plaintiffs described herein will hereinafter be referred to collectively as Plaintiff-heirs.

c. Plaintiff, Princie Black is the Administratrix of the Estate of Ruffus M. Neal, a deceased patient in the Tuskegee Syphilis Study and represents all other administrators and executors appointed or which will be appointed in the future. Said Plaintiff will be hereinafter referred to as Plaintiff-Administratrix.

2. Defendants.

a. Defendant, The United States of America, is ultimately responsible for the acts as hereinafter more fully appear.

b. Defendant, Department of Health, Education and Welfare is an Agency of the United States of America and has overall responsibility for the Tuskegee Syphilis Study.

c. Defendant, United States Public Health Service is a part of the Department of Health, Education and Welfare and is primarily in charge of the Tuskegee Syphilis Study.

d. Defendant, the United States Center for Disease Control, Venereal Disease Branch, is a branch of the United States Public Health Service and actually carried out much of the Tuskegee Syphilis Study.

e. Defendant, Caspar Weinberger is Secretary of the Department of Health, Education and Welfare, and is sued in his official capacity.

f. Defendant, Dr. Charles C. Edwards, is the Chief of the Public Health Service and is sued in his official capacity.

g. Defendant, Dr. J. D. Millar, is Chief of the Venereal Disease Branch of the Center for Disease Control and is sued in his official capacity.

h. Defendant, Dr. Donald Printz is Assistant Chief of the Venereal Disease Branch for the Center for Disease Control and is sued in his official capacity.

i. Defendant, State of Alabama, participated in cooperation with the other defendants herein in the Tuskegee Syphilis Study.

j. Defendant, The State Board of Health is a State of Alabama governmental agency organized and existing pursuant to the Laws of the State of Alabama. Its duties include the general supervision of State Health Laws in Alabama and said agency participated in the Tuskegee Syphilis Study.

k. Defendant, Dr. Ira L. Meyers, is Alabama's State Health Officer and is the Executive Officer of The State Board of Health. He is sued in his official capacity.

l. Defendant, Milbank Memorial Fund, a Corporation, is a non-profit corporation which provided funds for pathological examinations and a burial allowance for the participants in the Tuskegee Syphilis Study who were autopsied. It is sued individually.

m. Defendant, Dr. John R. Heller is over the age of 21 years, a citizen of the United States of America and is sued individually.

n. Defendant, Dr. Sidney Olansky, is a person over the age of 21 years and a citizen of the United States of America and is sued individually.

o. Defendants, Dr. John Doe, Drs. A through Z, whose names are otherwise unknown to the Plaintiffs but whose names will be inserted when ascertained,

are all medical doctors who are licensed to practice medicine and were so licensed at the time and during the events hereinafter described occurred. Each said doctor is a person over the age of 21 years and a citizen of the United States of America and each participated in said Study as hereinafter more fully appears in his professional capacity as a medical doctor.

III. Class Action

a. The Plaintiff-Subjects are more particularly specified in paragraph II 1(a) above bring this action on behalf of themselves and on behalf of all others the same or similarly situated pursuant to Rule 23 of The Federal Rules of Civil Procedure. The prerequisites of sections (a), (b)(1), (b)(2) and (b)(3) of Rule 23 are satisfied. The claims of the Plaintiff-Subjects are typical of the claims of all others the same or similarly situated. The class represented by Plaintiff-Subjects is the class of persons who, because of circumstances beyond their control, were subject to the Tuskegee Syphilis Study experiment by Defendants herein.

The questions of law and fact common to the members of the class predominate over any questions affecting only individual members and a class action will provide for fair and efficient adjudication of the controversy.

b. The Plaintiff-Heirs as more particularly specified in paragraph II 1(b) above bring this action on behalf of themselves and on behalf of all others the same or similarly situated pursuant to Rule 23 of the Federal Rules of Civil Procedure.

The prerequisites of sections (a), (b)(1), (b)(2) and (b)(3) of Rule 23 are satisfied. The claims of the Plaintiff-Heirs are typical of the claims of all others the same or similarly situated. The class represented by Plaintiff-Heirs is the class of persons who are heirs of the deceased subjects. They, as a class, suffer the same degradation and humiliation because of conditions beyond their control as the class [of] Plaintiff-Subjects specified in paragraph III (a) above. Additionally, their relatives are lost through death and serious injury and therefore these Plaintiff-Heirs and the class they represent suffer loss of wrongful death of a person to whom they are related.

c. The Plaintiff-Administratrix, as more particularly specified in Paragraph II 1 (c) above brings this action on behalf of herself as administratrix of the Estate of Ruffus M. Neal and on behalf of all other administrators and executors the same or similarly situated. The prerequisites of sections (a), (b)(1), (b)(2) and (b)(3) of Rule 23 are satisfied. The claims of the Plaintiffs are typical of the claims of all others the same or similarly situated. The class represented by Plaintiff-Administratrix is the class of persons who are administrators or executors now appointed or which in the future will be appointed to represent estates of those deceased subjects of the Tuskegee Syphilis Study.

The questions of law and fact common to the members of the class predominate over any questions affecting only individual members and a class action will provide for an efficient adjudication of the controversy.

IV. Allegations of Fact

1. The Tuskegee Syphilis Study, a shocking 40-year study in human experimentation, was designed to observe the effects of untreated syphilis. The subjects were poor Southern, rural blacks of limited education, who knew nothing of their role as experimental subjects.

2. Plaintiffs allege on information and belief that so far as they are concerned, the Tuskegee Syphilis Study began in 1932 when notices were issued by Defendants, their servants, agents, employees and others acting in concert and participation with them, announcing an alleged new health program in Macon County, Alabama. These notices were circulated throughout the county, by mail, at black schools, and [at] black churches. Only blacks were given the notices and only black males were subsequently selected to participate in the program.

3. In this manner, approximately 600 black males were recruited for the experiment. They were broken down into three groups. One group consisted of syphilitics who had never received treatments for the disease. The second group consisted of those who showed no symptoms of the disease. The third group consisted of those who had received treatment for syphilis during the first two years of infection.

4. At the time the study began, treatment for syphilis was uncertain and dangerous. Penicillin became generally available only after World War II.

5. The two groups of syphilitic black males were denied all treatments and have continuously been denied treatment for syphilis by the Defendants at the date of the filing of this Complaint. Indeed, this was the expressed purpose of the study, i.e., to study the effects of untreated syphilis, and this remained the object in the 1940s and after a massive nationwide drive to wipe out syphilis was undertaken. Those so subjected to said study, living or dead, are hereinafter referred to as subjects.

6. The black men who were recruited for the experiment were never told why they were being sought out nor the nature of the program. In fact, the Defendants, their agents, servants, or employees while acting within the line and scope as said agents, servants or employees (a) purposefully did not inform those subjects found to be syphilitic that that they had syphilis and intentionally withheld this information from them; and (b) represented or gave the impression by words and actions reasonably inferred by the subjects, they were getting adequate medical treatment. Such representations or impressions were false and were known to be false by the Defendants or each of them, their servants, agents or employees. Subjects reasonably rely on such representations

and impressions as to their state of health. Subjects went through some 40 years of experimentation based on said representations and impressions.

7. These impressions and representations were maintained and the experiment continued by examinations of said subjects approximately every year or every two years by Defendants, their servants, agents, employees, or others acting in concert and participation with them as part of the study. Throughout, said subjects were not advised that they had syphilis, were not treated for syphilis and were even dissuaded or prevented from receiving medical treatment for their syphilis which was generally made available to other non-subjects and which said subjects would have received had they not been subjects.

8. Many of the participants in the untreated syphilis control group have died since 1932. Plaintiffs allege upon information and belief that many of the deaths were directly related to the effects of untreated syphilis and treatment was knowingly withheld from the subjects even through available.

9. At death, pathological examinations were made on the subjects and a small allowance was given to the families of those autopsied by Defendant, Milbank Memorial Fund, a Corporation.

10. The subjects of the study were unaware of its nature or purpose. Plaintiffs did not become aware of the nature of the study or of the subjects' role therein until notified by the Defendants, their agents, servants, or employees during the month of April, 1973, or thereafter.

11. Said subjects never gave their informed or knowing consent to be subjects in such an experiment. At least one-fourth of the subjects had no formal education at all, and most of the remaining subjects had six years or less. Many, therefore, were also incapable of giving informed or knowing consent.

12. The subjects were not paid or in any other way compensated for their services, other than as provided in paragraph 9, *supra*.

13. The subjects of the study were racially selected: only black men were used as subjects in the study. The Tuskegee Syphilis Study was situated exclusively in Macon County, Alabama which is predominately black, although there were many whites living in Macon County who had syphilis. No white persons were solicited or used in the study as subjects. Plaintiffs allege that the black subjects were selected and used in the experiment, a program of controlled genocide solely because of their race and color in violation of their rights, secured by the Constitution and laws of the United States.

14. All subjects were black, poor and uneducated. Defendants exploited this condition in violation of rights guaranteed under the Fifth, Ninth, Thirteenth and Fourteenth

Amendments to the Constitution of the United States and Article I, Section 6 of the Alabama Constitution of 1901.

15. Said subjects suffered from this experiment numerous harms from being the subject of such experimentation, including but not limited to: physical and mental disability, affliction, distress, pain, discomfort and suffering; death; loss of earnings; racial discrimination; false and misleading information about their state of health; improper treatment or lack of treatment; lowering of tolerance to other physical and mental illnesses; use as subjects in human experimentation without informed consent; the maintenance of Plaintiff-Subjects as carriers of a communicable disease that can cause harm to others, including birth defects is children born of mothers to whom the disease has been communicated and the shortening of their lives.

16. Plaintiffs further aver that they have suffered said injuries and damages described above as a proximate consequence and result of the aforesaid negligence of the Defendants, their servants, agents or employees while acting within the line and scope as such servants, agents or employees.

17. Plaintiffs further aver that they have suffered said injuries and damages described above as a proximate consequence and result of the aforesaid willfulness and wantonness of the Defendants, their servants, agents or employees while acting within the line and scope as such servants, agents or employees.

V. Prayer for Relief

WHEREFORE, THE PREMISES CONSIDERED: Plaintiffs respectfully pray:

1. That upon a final determination of this cause, the Court enter a Declaratory Judgment declaring:

a. The actions of all the defendants to be violative and repugnant to the Fifth, Ninth, Thirteenth and Fourteenth Amendments to the United States Constitution, and Article I, Section 6, of the Alabama Constitution of 1901.

b. That each living Plaintiff-Subject and the class that they represent be awarded ONE MILLION FIVE-HUNDRED THOUSAND AND NO/100 ($1,500,000.00) Dollars, each as damages for the deprivation of rights secured to them under the laws of the United States Constitution and the Laws of the State of Alabama.

c. That the Plaintiff-Heirs and/or the personal representative of each of the deceased subjects and the class that they represent be awarded ONE MILLION FIVE-HUNDRED THOUSAND AND NO/100 ($1,500,000.00) Dollars, each as damages for the deprivation of rights secured to them under the Laws of the United States, the United States Constitution and the Laws of the State of Alabama.

d. That each living Plaintiff-Subject and the class that they represent be awarded ONE MILLION FIVE-HUNDRED THOUSAND AND NO/100 ($1,500,000.00) Dollars in addition to the amount demanded in paragraph "b" above as damages under the Federal Tort Claim Act.

e. That the Plaintiff-Heirs and/or the personal representative of each of the deceased subjects and the class that they represent be awarded ONE MILLION FIVE-HUNDRED THOUSAND AND NO/100 ($1,500,000.00) Dollars in addition to the amount demanded in paragraph "c" above as damages under the Federal Tort Claim Act.

f. That Plaintiffs be awarded reasonable attorney's fees to be taxed as part of the costs of this proceeding.

2. That upon final determination of this cause, this Count enter a permanent injunction enjoining and restraining defendants: The United States of America: the Department of Health, Education and Welfare; the United States Center for Disease Control – Venereal Disease Branch; the Milbank Fund, a Corporation; the State of Alabama; the State Board of Health; Dr. Ira L. Myers, Alabama State Health Officer; Caspar Weinberger, as Secretary of the Department of Health, Education and Welfare; Dr. J. D. Millar, as Chief of the Center for Disease Control – Venereal Disease Branch; Dr. Donald Printz, as Assistant Chief, Center for Disease Control – Venereal Disease Branch; and their successors in office, their servants, agents, employees and all other persons acting in concert and participation with them:

a. From conducting or continuing to conduct in anyway, now or in the future, The Tuskegee Syphilis Study.

b. From conducting or continuing to conduct in anyway, now or in the future, experiments on human beings without their full knowledge and informed consent and without minimum medical safeguards for experimentations on human beings, and

c. From conducting experiments on human beings where their death or injury could be prevented.

3. That this Court grant to Plaintiffs, such other, further and different relief as they may be entitled from the premises and proof in this cause.

Respectfully submitted,

GRAY, SEAY & LANGFORD, P.A.

BY: (signed Fred D. Gray)
Attorneys for Plaintiffs

Post Office Box 239
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OF COUNSEL:

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APPLICATION OF THE PRESIDENT AND DIRECTORS OF GEORGETOWN COLLEGE, INC

United States Court of Appeals, District of Columbia Circuit, 1964
331 F.2d 1000

Opinion by Skelly Wright.

Attorneys for Georgetown Hospital applied for an emergency writ at 4:00 P.M., September 17, 1963, seeking relief from the action of the United States District Court for the District of Columbia denying the hospital's application for permission to administer blood transfusions to an emergency patient. The application recited that "Mrs. Jesse E. Jones is presently a patient at Georgetown University Hospital," "she is in extremis," according to the attending physician "blood transfusions are necessary immediately in order to save her life," and "consent to the administration thereof can be obtained neither from the patient nor her husband." The patient and her husband based their refusal on their religious beliefs as Jehovah's Witnesses. The order sought provided that the attending physicians *may* administer such transfusions to Mrs. Jones as might be "necessary to save her life." After the proceedings detailed in Part IV of this opinion, I signed the order at 5:20 P.M.

I. [Background][43]

. . . The application was in the nature of a petition in equity to the United States District Court for the District of Columbia. . . . [seeking] a decree in the nature of an injunction and declaratory judgment to determine the legal rights and liabilities between the hospital and its agents, on the one hand, and Mrs. Jones and her husband, on the other. . . . The treatment proposed by the hospital . . . was not a single transfusion, but a series of transfusions. The hospital doctors sought a court determination before undertaking either this course of action or some alternative. The temporary order issued was more limited than the order proposed in the original application, in that the phrase 'to save her life' was added, thus limiting the transfusions in both time and number. . . .

. . .

[43] Added. Original Sections II and III of the opinion have been omitted and the remaining sections renumbered. The original Sections II and III deal with legal technicalities (existence of a case or controversy and the All Writs statute) and are neither necessary to a general understanding of the case nor to consideration of the ethical analysis in it.

[II. Facts]

. . .

Mrs. Jones was brought to the hospital, by her husband for emergency care, having lost two thirds of her body's blood supply from a ruptured ulcer. She had no personal physician, and relied solely on the hospital staff. She was a total hospital responsibility. It appeared that the patient, age 25, mother of a seven-month-old child, and her husband were both Jehovah's Witnesses, the teachings of which sect, according to their interpretation, prohibited the injection of blood into the body.[44] When death without blood became imminent, the hospital sought the advice of counsel, who applied to the District Court in the name of the hospital for permission to administer blood. Judge Tamm of the District Court denied the application, and counsel immediately applied to me, as a member of the Court of Appeals, for an appropriate writ.

I called the hospital by telephone and spoke with Dr. Westura, Chief Medical Resident, who confirmed the representations made by counsel. I thereupon proceeded with counsel to the hospital, where I spoke to Mr. Jones, the husband of the patient. He

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[44] Added. from *Health Law for Federal Sector Administrators*, 540-541, Karin W. Zucker and Martin J. Boyle, eds. (not formally published; printed by the Army Medical Department Center and School, 8th ed., 2000).

Jehovah's Witnesses base their refusal of blood transfusions on several Biblical texts. Among those are *Leviticus* 17:10-12; *Acts* 15:28-29; and *Hebrews* 9:11-22.

> And whatsoever man there be of the house of Israel, or of the strangers that sojourn among you, that eateth any manner of blood; I will even set my face against that soul that eateth blood, and will cut him off from among his people. *Leviticus* 17: 10-12, King James Version (KJV).
>
> For it seemed good to the Holy Ghost, and to us, to lay upon you no greater burden than these necessary things; that ye abstain from meats offered to idols, and from blood, and from things strangled, and from fornication; from which if ye keep yourselves, ye shall do well. *Acts* 15:28-29, KJV.
>
> But Christ being come an high priest of good things to come, by a greater and more perfect tabernacle, not made with hands, that is to say, not of this building; neither by the blood of goats and calves, but by his own blood he entered in once into the holy place, having obtained eternal redemption for us. For if the blood of bulls and of goats, and the ashes of an heifer sprinkling the unclean, sanctifieth to the purifying of the flesh; how much more shall the blood of Christ, who through the eternal Spirit offered himself without spot to God, purge your conscience from dead works to serve the living God? And for this cause he is the mediator of the new testament, that by means of death, for the redemption of the trans-gressions that were under the first testament, they which are called might receive the promise of eternal inheritance. For where a testament is, there must also of necessity be the death of the testator. For a testament is of force after men are dead: otherwise it is of no strength at all while the testator liveth. Whereupon neither the first testament was dedicated without blood. For when Moses had spoken every precept to all the people according to the law, he took the blood of calves and of goats, with water, and scarlet wool, and hyssop, and sprinkled both the book, and all the people, saying. 'This is the blood of the testament which God hath enjoined unto you.' Moreover he sprinkled with blood both the tabernacle, and all the vessels of the ministry. And almost all things are by the law purged with blood; and without shedding of blood is no remission. *Hebrews* 9:11-22, *KJV*.

advised me that, on religious grounds, he would not approve a blood transfusion for his wife. He said, however, that if the court ordered the transfusion, the responsibility was not his. I advised Mr. Jones to obtain counsel immediately. He thereupon went to the telephone and returned in 10 or 15 minutes to advise that he had taken the matter up with his church and that he had decided that he did not want counsel.

I asked permission of Mr. Jones to see his wife. This he readily granted. Prior to going into the patient's room, I again conferred with Dr. Westura and several other doctors assigned to the case. All confirmed that the patient would die without blood and that there was a better than 50% chance of saving her life with it. Unanimously they strongly recommended it. I then went inside the patient's room. Her appearance confirmed the urgency which had been represented to me. I tried to communicate with her, advising her again as to what the doctors had said. The only audible reply I could hear was 'Against my will.' It was obvious that the woman was not in a mental condition to make a decision. I was reluctant to press her because of the seriousness of her condition and because I felt that to suggest repeatedly the imminence of death without blood might place a strain on her religious convictions. I asked her whether she would oppose the blood transfusion if the court allowed it. She indicated, as best I could make out, that it would not then be her responsibility.

I returned to the doctors' room where some 10 to 12 doctors were congregated, along with the husband and counsel for the hospital. The President of Georgetown University, Father Bunn, appeared and pleaded with Mr. Jones to authorize the hospital to save his wife's life with a blood transfusion. Mr. Jones replied that the Scriptures say that we should not drink blood, and consequently his religion prohibited transfusions. The doctors explained to Mr. Jones that a blood transfusion is totally different from drinking blood in that the blood physically goes into a different part and through a different process in the body. Mr. Jones was unmoved. I thereupon signed the order allowing the hospital to administer such transfusions as the doctors should determine were necessary to save her life.

[III. Discussion and Conclusion]

. . .

Before proceeding with this inquiry, it may be useful to state what this case does not involve. This case does not involve a person who, for religious or other reasons, has refused to seek medical attention. It does not involve a disputed medical judgment or a dangerous or crippling operation. Nor does it involve the delicate question of saving the newborn in preference to the mother. Mrs. Jones sought medical attention and placed on the hospital the legal responsibility for her proper care. In its dilemma, not of its own making, the hospital sought judicial direction.

It has been firmly established that the courts can order compulsory medical treatment of children for any serious illness or injury, e.g., *People ex rel. Wallace v.*

Labrenz, 104 N.E.2d 769, cert. denied, 344 U.S. 824 (1952); *Morrison v. State, 252* S.W.2d 97 (MO, 1952); *Mitchell v. Davis,* 205 S.W.2d 812 (TX, 1947), and that adults, sick or well, can be required to submit to compulsory treatment or prophylaxis, at least for contagious diseases, e.g., *Jacobson v. Massachusetts,* 197 U.S. 11, (1905). And, there are no religious exemptions from these orders, e.g., *People ex rel. Wallace v. Labrenz, supra*; cf. *Hamilton v. Regents,* 293 U.S. 245 (1934), rehearing denied, 293 U.S. 633 (1935). These principles were restated by the Supreme Court in *Prince v. Massachusetts,* 321 U.S. 158 (1944):

> Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parents' control. . . . Its authority is not nullified merely because the parent grounds his claim to control the child's course of conduct on religion or conscience. Thus, he cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds. *Jacobson v. Massachusetts,* 197 U.S. 11 (1905). The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death. *People v. Pierson,* 68 N.E. 243 (NY, 1905).

Of course, there is here no sick child or contagious disease. However, the sick child cases may provide persuasive analogies because 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 of general jurisdiction, such as the United States District Court for the District of Columbia, to assume the responsibility of guardianship for her, as for a child, at least to the extent of authorizing treatment to save her life. And if, as shown above, a parent has no power to forbid the saving of his child's life, a fortiori the husband of the patient here had no right to order the doctors to treat his wife in a way so that she would die.

The child cases point up another consideration. The 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.

Apart from the child cases, a second range of factors may be considered. It is suggested that an individual's liberty to control himself and his life extends even to the liberty to end his life. Thus, "those states where attempted suicide has been made lawful by statute (or the lack of one), the refusal of necessary medical aid (to one's self), whether equal to or less than attempted suicide, must be conceded to be lawful." Cawley, "Criminal Liability in Faith Healing," *39 Minn. L. Rev.* 48, 68 (1954). And, conversely, it would follow that where attempted suicide is illegal by the common law or by statute, a person may not be allowed to refuse necessary medical assistance when death is likely to ensue without it. Only quibbles about the distinction between

misfeasance and nonfeasance,[45] or the specific intent necessary to be guilty of attempted suicide, could be raised against this latter conclusion.

If self-homicide is a crime, there is no exception to the law's command for those who believe the crime to be divinely ordained. The Mormon cases in the Supreme Court establish that there is no religious exception to criminal laws, and state *obiter* the very example that a religiously-inspired suicide attempt would be within the law's authority to prevent. *Reynolds v. United States,* 98 U.S. (8 Otto) 145 (1878); *Late Corporation of the Church of Jesus Christ of Latter-Day Saints v. United States* (*Romney v. United States*), 136 U.S. 1 (1890). But whether attempted suicide is a crime is in doubt in some jurisdictions, including the District of Columbia.[46]

The Gordian knot[47] of this suicide question may be cut by the simple fact that Mrs. Jones did not want to die. Her voluntary presence in the hospital as a patient seeking medical help testified to this. Death, to Mrs. Jones, was not a religiously-commanded goal, but an unwanted side effect of a religious scruple. There is no question here of interfering with one whose religious convictions counsel his death, like the Buddhist monks who set themselves afire. . . . Mrs. Jones wanted to live.

A third set of considerations involved the position of the doctors and the hospital. Mrs. Jones was their responsibility to treat. The hospital doctors had the choice of administering the proper treatment or letting Mrs. Jones die in the hospital bed, thus exposing themselves, and the hospital, to the risk of civil and criminal liability in either case. It is not certain that Mrs. Jones had any authority to put the hospital and its doctors to this impossible choice. The normal principle that an adult patient directs her doctors is based on notions of commercial contract which may have less relevance to life-or-death emergencies. It is not clear just where a patient would derive her authority to command her doctor to treat her under limitations which would produce death. The patient's counsel suggests that this authority is part of constitutionally protected liberty. But neither the principle that life and liberty are inalienable rights, nor the principle of liberty of religion, provides an easy answer to the question whether the state can prevent martyrdom. Moreover, Mrs. Jones had no wish to be a martyr. And

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[45] Added. *Misfeasance* is the improper doing of a lawful act; *nonfeasance* is the omission of an act that should have been done.

[46] 22 D.C. Code §2401 (1961). "Whoever . . . kills another (etc.) is guilty of murder. . . ."

[47] Added. The story of the Gordian knot is a Greek legend, which itself poses interesting ethical questions. An oracle had told the rulerless population of Phrygia that their king would be he who arrived riding in a wagon. Shortly thereafter, Gordias, a poor peasant, came riding in an oxcart. Following the prophecy of the oracle, the Phrygians made him their king. In gratitude, Gordias dedicated his oxcart or his tools, depending upon the version of the story, to Zeus, securing it, or them, in with a knot that could not be untied. When Gordias died his son Midas became King of Phrygia. When he died, the city was once again without a king, and again the oracle spoke; this time saying that the king would be the one who could untie the knot Gordias had tied. Many tried but did not succeed. Later legend has it that Alexander the Great tried also and, becoming enraged when he failed, drew his sword and cut the knot. –Should *cutting the Gordian knot* be a matter of pride or shame?

her religion merely prevented her consent to a transfusion. If the law undertook the responsibility of authorizing the transfusion without her consent, no problem would be raised with respect to her religious practice. Thus, the effect of the order was to preserve for Mrs. Jones the life she wanted without sacrifice of her religious beliefs.

The final, and compelling, reason for granting the emergency writ was that a life hung in the balance. There was no time for research and reflection. Death could have mooted the cause in a matter of minutes, if action were not taken to preserve the status quo. To refuse to act, only to find later that the law required action, was a risk I was unwilling to accept. I determined to act on the side of life. –Writ granted.

IN THE MATTER OF KAREN QUINLAN

Supreme Court of New Jersey, 1976
355 A.2d 647

Opinion by Hughes.

I. The Litigation

The central figure in this tragic case is Karen Ann Quinlan, a New Jersey resident. At the age of 22, she lies in a debilitated and allegedly moribund state at Saint Clare's Hospital in Denville, New Jersey. The litigation has to do, in final analysis, with her life, -- its continuance or cessation -- and the responsibilities, rights and duties, with regard to any fateful decision concerning it, of her family, her guardian, her doctors, the hospital, the state through its law enforcement authorities, and finally the courts of justice.

. . .

Due to extensive physical damage . . . Karen allegedly was incompetent. Joseph Quinlan sought the adjudication of that incompetency. He wished to be appointed guardian of the person and property of his daughter. It was proposed by him that such letters of guardianship, if granted, should contain an express power to him as guardian to authorize the discontinuance of all extraordinary[48] medical procedures now allegedly sustaining Karen's vital processes and hence her life, since these measures, he asserted, present no hope of her eventual recovery. A guardian *ad litem* was appointed by Judge Muir to represent the interest of the alleged incompetent.

. . . [I]n view of the extraordinary nature of the relief sought by plaintiff and the involvement therein of their several rights and responsibilities, other parties were added. These included the treating physicians and the hospital, the relief sought being that they be restrained from interfering with the carrying out of any such extraordinary authorization in the event it were to be granted by the court. Joined, as well, was the Prosecutor of Morris County (he being charged with responsibility for enforcement of the criminal law), to enjoin him from interfering with, or projecting a criminal prosecution which otherwise might ensue in the event of, cessation of life in Karen

[48] Added. The term *extraordinary* as used here does not mean *unusual* or *uncommon*; it is part of the phrase *extraordinary means* and has a very specific meaning in Roman Catholic moral theology. "*Extraordinary means* is a bioethical term generally encompassing those drugs, devices, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience or which, if used, would offer no reasonable hope of benefit." Conversely, "*ordinary means* is a bioethical term encompassing drugs, devices, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience." [Emphasis added.] *Health Law for Federal Sector Administrators*, Glossary, Karin Waugh Zucker and Martin J. Boyle, eds. (not formally published; printed by the Army Medical Department Center and School, 8th ed., 2000).

resulting from the exercise of such extraordinary authorization were it to be granted to the guardian.

The Attorney General of New Jersey intervened as of right pursuant to . . . the interest of the state in the preservation of life, which has an undoubted constitutional foundation.

The matter is of transcendent importance, involving questions related to the definition and existence of death; the prolongation of life through artificial means developed by medical technology undreamed of in past generations of the practice of the healing arts; the impact of such durationally indeterminate and artificial life prolongation on the rights of the incompetent, her family and society in general; the bearing of constitutional right and the scope of judicial responsibility, as to the appropriate response of an equity court of justice to the extraordinary prayer for relief of the plaintiff. Involved as well is the right of the plaintiff, Joseph Quinlan, to guardianship of the person of his daughter.

. . .

[All parties stipulated that [u]nder any legal standard recognized by the State of New Jersey and also under standard medical practice, Karen Ann Quinlan is presently alive.]

The Prosecutor of Morris County sought a declaratory judgment as to the effect any affirmation by the court of a right in a guardian to terminate life-sustaining procedures would have with regard to enforcement of the criminal laws of New Jersey with reference to homicide. Saint Clare's Hospital, in the face of trial testimony on the subject of *brain death*, sought declaratory judgment as to:

> Whether the use of the criteria developed and enunciated by the Ad Hoc Committee of the Harvard Medical School on or about August 5, 1968,[49]

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[49] Added from *Health Law for Federal Sector Administrators*, *supra*, 578-579. The *Harvard Criteria* are set forth and commented upon, as follows, in *Defining Death*, a report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

> 1. Unreceptivity and unresponsivity. The patient shows a total unawareness to externally applied stimuli and inner need, and complete unresponsiveness, even when intensely painful stimuli are applied.
>
> 2. No movements or breathing. All spontaneous muscular movement, spontaneous respiration, and response to stimuli such as pain, touch, sound, or light are absent.
>
> 3. No reflexes. Among the indications of absent reflexes are: fixed, dilated pupils; lack of eye movement even when the head is turned or ice water is placed in the ear; lack of response to noxious stimuli; and generally, unelicitable tendon reflexes.
>
> In addition to these three criteria, a flat electroencephalogram, which shows that there is no discernible electrical activity in the cerebral cortex, was recommended as a confirmatory test, when available. All tests were to be repeated at last 24 hours later without showing change. Drug

> as well as similar criteria, by a physician to assist in determination of the death of a patient whose cardiopulmonary functions are being artificially sustained, is in accordance with ordinary and standard medical practice.

It was further stipulated during trial that Karen was indeed incompetent and guardianship was necessary, although there exists a dispute as to the determination later reached by the court that such guardianship should be bifurcated, and that Mr. Quinlan should be appointed as guardian of the trivial property but not the person of his daughter.

. . . [T]he Attorney General filed . . . a cross-appeal challenging the action of the trial court in admitting evidence of prior statements made by Karen while competent as to her distaste for continuance of life by extraordinary medical procedures, under circumstances not unlike those of the present case. These quoted statements were made in the context of several conversations with regard to others terminally ill and being subjected to like heroic measures. The statements were advanced as evidence of what she would want done in such a contingency as now exists. She was said to have firmly evinced her wish, in like circumstances, not to have her life prolonged by the otherwise futile use of extraordinary means. [However,]] we agree with the conception of the trial court that such statements . . .were remote and impersonal, [and] lacked significant probative weight. . . .

. . .

Essentially then, appealing to the power of equity, and relying on claimed constitutional rights of free exercise of religion, of privacy and of protection against cruel and unusual punishment, Karen Quinlan's father sought judicial authority to withdraw the life-sustaining mechanisms temporarily preserving his daughter's life, and his appointment as guardian of her person to that end. His request was opposed by her doctors, the hospital, the Morris County Prosecutor, the State of New Jersey, and her guardian *ad litem*.

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intoxication (e.g., barbiturates) and hypothermia (body temperature below 90 degrees F, which can cause a reversible loss of brain functions, also had to be excluded before the criteria could be used.

The Harvard criteria have been found to be quite reliable. Indeed, no case has yet been found that met these criteria and regained any brain functions despite continuation of respirator support. Criticisms of the criteria have been of five kinds. First, the phrase irreversible coma is misleading as applied to the cases at hand. Coma is a condition of a living person, and a body without any brain functions is dead and thus beyond any coma. Second the writers of these criteria did not realize that the spinal cord reflexes actually persist or return quite commonly after the brain has completely and permanently ceased functioning. Third, unreceptivity is not amenable to testing in an unresponsive body without consciousness. Next, the need adequately to test brainstem reflexes, especially apnea, and to exclude drug and metabolic intoxication as possible causes of the coma, are not made sufficiently explicit and precise. Finally, although all individuals that meet the Harvard criteria are dead (irreversible cessation of all functions of the entire brain), there are many other individuals who are dead but do not maintain circulation long enough to have a 24-hour observation period.

II. The Factual Base

. . .

On the night of April 15, 1975, for reasons still unclear, Karen Quinlan ceased breathing for at least two 15-minute periods. She received some ineffectual mouth-to-mouth resuscitation from friends. She was taken by ambulance to Newton Memorial Hospital. There she had a temperature of 100 degrees, her pupils were unreactive and she was unresponsive even to deep pain. The history at the time of her admission to that hospital was essentially incomplete and uninformative.

Three days later, Dr. Morse examined Karen at the request of the Newton Memorial Hospital admitting physician, Dr. McGee. He found her comatose with evidence of decortication, a condition relating to derangement of the cortex of the brain causing a physical posture in which the upper extremities are flexed and the lower extremities are extended. She required a respirator to assist her breathing. Dr. Morse was unable to obtain an adequate account of the circumstances and events leading up to Karen's admission to the Newton Hospital. Such initial history or etiology is crucial in neurological diagnosis. Relying as he did upon the Newton Memorial records and his own examination, he concluded that prolonged lack of oxygen in the bloodstream, anoxia, was identified with her condition as he saw it upon first observation. When she was later transferred to Saint Clare's Hospital she was still unconscious, still on a respirator, and a tracheotomy had been performed. On her arrival Dr. Morse conducted extensive and detailed examinations. An electroencephalogram (EEG) measuring electrical rhythm of the brain was performed and Dr. Morse characterized the result as "abnormal but it showed some activity and was consistent with her clinical state." Other significant neurological tests, including a brain scan, an angiogram, and a lumbar puncture were normal in result. Dr. Morse testified that Karen has been in a state of coma, lack of consciousness, since he began treating her. He explained that there are basically two types of coma, sleep-like unresponsiveness and awake unresponsiveness. Karen was originally in a sleep-like unresponsive condition but soon developed sleep-wake cycles, apparently a normal improvement for comatose patients occurring within three to four weeks. In the awake cycle she blinks, cries out and does things of that sort but is still totally unaware of anyone or anything around her.

Dr. Morse and other expert physicians who examined her characterized Karen as being in a *chronic persistent vegetative state*. Dr. Fred Plum, one of such expert witnesses, defined this as a "subject who remains with the capacity to maintain the vegetative parts of neurological function but who no longer has any cognitive function."

Dr. Morse, as well as the several other medical and neurological experts who testified in this case, believed with certainty that Karen Quinlan is not *brain dead.* They identified the Ad Hoc Committee of Harvard Medical School report as the ordinary medical standard for determining brain death,[50] and all of them were satisfied that Karen

[50] *Id.*

met none of the criteria specified in that report and was therefore not brain dead within its contemplation.

In this respect it was indicated by Dr. Plum that the brain works in essentially two ways, the vegetative and the sapient. He testified:

> We have an internal vegetative regulation which controls body temperature which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart rate, which controls chewing, swallowing and which controls sleeping and waking. We have a more highly developed brain which is uniquely human which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think. Brain death necessarily must mean the death of both of these functions of the brain, vegetative and the sapient. Therefore, the presence of any function which is regulated or governed or controlled by the deeper parts of the brain which in laymen's terms might be considered purely vegetative would mean that the brain is not biologically dead.

Because Karen's neurological condition affects her respiratory ability (the respiratory system being a brain stem function) she requires a respirator to assist her breathing. . . . Attempts to *wean* her from the respirator were unsuccessful and have been abandoned.

The experts believe that Karen cannot now survive without the assistance of the respirator; that exactly how long she would live without it is unknown; that the strong likelihood is that death would follow soon after its removal; and that removal would also risk further brain damage and would curtail the assistance the respirator presently provides in warding off infection.

It seemed to be the consensus not only of the treating physicians but also of the several qualified experts who testified in the case, that removal from the respirator would not conform to medical practices, standards, and traditions.

The further medical consensus was that Karen in addition to being comatose is in a chronic and persistent vegetative state, having no awareness of anything or anyone around her and existing at a primitive reflex level. Although she does have some brain stem function (ineffective for respiration) and has other reactions one normally associates with being alive, such as moving, reacting to light, sound and noxious stimuli, blinking her eyes, and the like, the quality of her feeling impulses is unknown. She grimaces, makes sterotyped cries and sounds and has chewing motions. Her blood pressure is normal.

Karen remains in the intensive care unit at Saint Clare's Hospital, receiving 24-hour care by a team of four nurses characterized, as was the medical attention, as excellent. She is nourished by feeding by way of a nasogastric tube and is routinely

examined for infection, which under these circumstances is a serious life threat. The result is that her condition is considered remarkable under the unhappy circumstances involved.

Karen is described as emaciated, having suffered a weight loss of at least 40 pounds, and undergoing a continuing deteriorative process. Her posture is described as fetal-like and grotesque; there is extreme flexion-rigidity of the arms, legs, and related muscles; and her joints are severely rigid and deformed.

From all of this evidence, and including the whole testimonial record, several basic findings in the physical area are mandated. Severe brain and associated damage, albeit of uncertain etiology, has left Karen in a chronic and persistent vegetative state. No form of treatment which can cure or improve that condition is known or available. As nearly as may be determined, considering the guarded area of remote uncertainties characteristic of most medical science predictions, she can *never* be restored to cognitive or sapient life. Even with regard to the vegetative level and improvement therein (if such it may be called) the prognosis is extremely poor and the extent unknown if it should in fact occur.

. . .

Developments in medical technology have obfuscated the use of the traditional definition of death. Efforts have been made to define irreversible coma as a new criterion for death, such as by the 1968 report of the Ad Hoc Committee of the Harvard Medical School (the Committee comprising ten physicians, an historian, a lawyer and a theologian), which asserted that:

> From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes; so the obvious criterion of no heart beat as synonymous with death was sufficiently accurate. In those times the heart was considered to be the central organ of the body; it is not surprising that its failure marked the onset of death. This is no longer valid when modern resuscitative and supportive measures are used. These improved activities can now restore life as judged by the ancient standards of persistent respiration and continuing heart beat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain damage. ["A Definition of Irreversible Coma," 205 *J.A.M.A.* 337, 339 (1968)].

The *ad hoc* standards, carefully delineated, included absence of response to pain or other stimuli, pupilary reflexes, corneal, pharyngeal and other reflexes, blood pressure, spontaneous respiration, as well as *flat* or isoelectric electro-encephalograms and the like, with all tests repeated "at least 24 hours later with no change."[51] In such

[51] *Id.*

circumstances, where all of such criteria have been met as showing *brain death*, the Committee recommends . . . :

> . . . Death is to be declared and *then* the respirator turned off. The decision to do this and the responsibility for it are to be taken by the physician-in-charge, in consultation with one or more physicians who have been directly involved in the case. It is unsound and undesirable to force the family to make the decision. [205 *J.A.M.A., supra,* at 338 (emphasis in original)].

But, as indicated, it was the consensus of medical testimony in the instant case that Karen, for all her disability, met none of these criteria. . . .

. . . We have adverted to the *brain death* concept and Karen's disassociation with any of its criteria, to emphasize the basis of the medical decision made by Dr. Morse. When plaintiff and his family, finally reconciled to the certainty of Karen's impending death, requested the withdrawal of life support mechanisms, he demurred. His refusal was based upon his conception of medical standards, practice and ethics described in the medical testimony, such as in the evidence given by another neurologist, Dr. Sidney Diamond, a witness for the State. Dr. Diamond asserted that no physician would have failed to provide respirator support at the outset, and none would interrupt its life-saving course thereafter, except in the case of cerebral death. In the latter case, he thought the respirator would in effect be disconnected from one already dead, entitling the physician under medical standards and, he thought, legal concepts, to terminate the supportive measures. . . .

. . .

We turn to that branch of the factual case pertaining to the application for guardianship, as distinguished from the nature of the authorization sought by the applicant. The character and general suitability of Joseph Quinlan as guardian for his daughter, in ordinary circumstances, could not be doubted. The record bespeaks the high degree of familial love which pervaded the home of Joseph Quinlan and reached out fully to embrace Karen, although she was living elsewhere at the time of her collapse. The proofs showed him to be deeply religious, imbued with a morality so sensitive that months of tortured indecision preceded his belated conclusion (despite earlier moral judgments reached by the other family members, but unexpressed to him in order not to influence him) to seek the termination of life-supportive measures sustaining Karen. A communicant of the Roman Catholic Church, as were other family members, he first sought solace in private prayer looking with confidence, as he says, to the Creator, first for the recovery of Karen and then, if that were not possible, for guidance with respect to the awesome decision confronting him.

To confirm the moral rightness of the decision he was about to make he consulted with his parish priest and later with the Catholic chaplain of Saint Clare's

Hospital. He would not, he testified, have sought termination if that act were to be morally wrong or in conflict with the tenets of the religion he so profoundly respects. He was disabused of doubt, however, when the position of the Roman Catholic Church was made known to him as it is reflected in the record in this case. While it is not usual for matters of religious dogma or concepts to enter a civil litigation (except as they may bear upon constitutional rights or, sometimes, familial matters; *cf. In re Adoption of E,* 59 N.J. 36 (1971)), they were rightly admitted in evidence here. The judge was bound to measure the character and motivations in all respects of Joseph Quinlan as prospective guardian; and insofar as these religious matters bore upon them, they were properly scrutinized and considered by the court.

Thus germane, we note the position of [the Roman Catholic] Church as illuminated by the record before us. We have no reason to believe that it would be at all discordant with the whole of Judeo-Christian tradition, considering its central respect and reverence for the sanctity of human life. It was in this sense of relevance that we admitted as *amicus curiae* the New Jersey Catholic Conference, essentially the spokesman for the various Catholic bishops of New Jersey, organized to give witness to spiritual values in public affairs in the statewide community. The position statement of Bishop Lawrence B. Casey, reproduced in the *amicus* brief, projects these views:

> . . . The request of plaintiff for authority to terminate a medical procedure characterized as an *extraordinary means*[52] *of treatment* would not involve euthanasia. This upon the reasoning expressed by Pope Pius XII in his *allocutio* (i.e., address) to anesthesiologists on November 24, 1957, when he dealt with the question:
>
> > Does the anesthesiologist have the right, or is he bound, in all cases of deep unconsciousness, even in those that are completely hopeless in the opinion of the competent doctor, to use modern artificial respiration apparatus, even against the will of the family?
>
> His answer made the following points:
>
> > 1. In ordinary cases the doctor has the right to act in this manner, but is not bound to do so unless this is the only way of fulfilling another certain moral duty.
> >
> > 2. The doctor, however, has no right independent of the patient. He can act only if the patient explicitly or implicitly, directly or indirectly gives him the permission.
> >
> > 3. The treatment as described in the question constitutes extraordinary means of preserving life and so there is no

[52] See note 48, *supra*, at page 123.

> obligation to use them nor to give the doctor permission to use them.
>
> 4. The rights and the duties of the family depend on the presumed will of the unconscious patient if he or she is of legal age, and the family, too, is bound to use only ordinary means.
>
> 5. This case is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life, and we must apply in this case the principle of double effect.

So it was that the Bishop Casey statement validated the decision of Joseph Quinlan:

> Competent medical testimony has established that Karen Ann Quinlan has no reasonable hope of recovery from her comatose state by the use of any available medical procedures. The continuance of mechanical (cardiorespiratory) supportive measures to sustain continuation of her body functions and her life constitute extraordinary means of treatment. *Therefore, the decision of Joseph Quinlan to request the discontinuance of this treatment is, according to the teachings of the Catholic Church, a morally correct decision.* (emphasis in original)

And the mind and purpose of the intending guardian were undoubtedly influenced by factors included in the following reference to the interrelationship of the three disciplines of theology, law, and medicine as exposed in the Casey statement:

> The right to a natural death is one outstanding area in which the disciplines of theology, medicine, and law overlap; or, to put it another way, it is an area in which these three disciplines converge.
>
> Medicine with its combination of advanced technology and professional ethics is both able and inclined to prolong biological life. Law with its felt obligation to protect the life and freedom of the individual seeks to assure each person's right to live out his human life until its natural and inevitable conclusion. Theology with its acknowledgment of man's dissatisfaction with biological life as the ultimate source of joy defends the sacredness of human life and defends it from all direct attacks.
>
> These disciplines do not conflict with one another, but are necessarily conjoined in the application of their principles in a particular instance such as that of Karen Ann Quinlan. Each must in some way acknowledge the other without denying its own competence. The civil law is not expected to assert a belief in eternal life; nor, on the

other hand, is it expected to ignore the right of the individual to profess it, and to form and pursue his conscience in accord with that belief. Medical science is not authorized to directly cause natural death; nor, however, is it expected to prevent it when it is inevitable and all hope of a return to an even partial exercise of human life is irreparably lost. Religion is not expected to define biological death; nor, on its part, is it expected to relinquish its responsibility to assist man in the formation and pursuit of a correct conscience as to the acceptance of natural death when science has confirmed its inevitability beyond any hope other than that of preserving biological life in a merely vegetative state.

And the gap in the law is aptly described in the Bishop Casey statement:

> In the present public discussion of the case of Karen Ann Quinlan it has been brought out that responsible people involved in medical care, patients and families have exercised the freedom to terminate or withhold certain treatments as extraordinary means in cases judged to be terminal, i.e., cases which hold no realistic hope for some recovery, in accord with the expressed or implied intentions of the patients themselves. To whatever extent this has been happening it has been without sanction in civil law. Those involved in such actions, however, have ethical and theological literature to guide them in their judgments and actions. Furthermore, such actions have not in themselves undermined society's reverence for the lives of sick and dying people.
>
> It is both possible and necessary for society to have laws and ethical standards which provide freedom for decisions, in accord with the expressed or implied intentions of the patient, to terminate or withhold extraordinary treatment in cases which are judged to be hopeless by competent medical authorities, without at the same time leaving an opening for euthanasia. Indeed, to accomplish this, it may simply be required that courts and legislative bodies recognize the present standards and practices of many people engaged in medical care who have been doing what the parents of Karen Ann Quinlan are requesting authorization to have done for their beloved daughter.

Before turning to the legal and constitutional issues involved, we feel it essential to reiterate that the Catholic view of religious neutrality in the circumstances of this case is considered by the court only in the aspect of its impact upon the conscience, motivation and purpose of the intending guardian, Joseph Quinlan, and not as a precedent in terms of the civil law.

If Joseph Quinlan, for instance, were a follower and strongly influenced by the teachings of Buddha, or if, as an agnostic or atheist, his moral judgments were formed without reference to religious feelings, but were nevertheless formed and viable, we would with equal attention and high respect consider these elements, as bearing upon

his character, motivations and purposes as relevant to his qualification and suitability as guardian.

It is from this factual base that the court confronts and responds to three basic issues:

1. Was the trial court correct in denying the specific relief requested by plaintiff, *i.e.*, authorization for termination of the life-supporting apparatus, on the case presented to him? Our determination on that question is in the affirmative.

2. Was the court correct in withholding letters of guardianship from the plaintiff and appointing in his stead a stranger? On that issue our determination is in the negative.

3. Should this court, in the light of the foregoing conclusions, grant declaratory relief to the plaintiff? On that question our court's determination is in the affirmative.

This brings us to a consideration of the constitutional and legal issues underlying the foregoing determinations.

III. Constitutional and Legal Issues

. . .

A. The Free Exercise of Religion

We think the contention as to interference with religious beliefs or rights may be considered and dealt with without extended discussion, given the acceptance of distinctions so clear and simple in their precedential definition as to be dispositive on their face.

Simply stated, the right to religious beliefs is absolute but conduct in pursuance thereof is not wholly immune from governmental restraint. So it is that, for the sake of life, courts sometimes (but not always) order blood transfusions for Jehovah's Witnesses (whose religious beliefs abhor such procedure), *Application of President & Directors of Georgetown College, Inc.*, 331 F. 2d 1000, cert. den., 377 U.S. 978 (1964); *United States v. George,* 239 F. Supp. 752 (1965); but see *In re Osborne*, 294 A. 2d 372 (DC, 1972); *In re Estate of Brooks,* 205 N.E. 2d 435 (IL, 1965); *Erickson v. Dilgard,* 252 N.Y.S. 2d 705 (1962); *see generally* Annot., "Power Of Courts Or Other Public Agencies, In The Absence of Statutory Authority, To Order Compulsory Medical Care for Adult," 9 *A.L.R. 3d* 1391 (1966); forbid exposure to death from handling virulent snakes or ingesting poison (interfering with deeply held religious sentiments in such regard), *e.g., Hill v. State,* 88 So. 2d 880, cert. den., 88 So. 2d 887 (AL, 1956); *State ex rel. Swann v. Pack*, 527 S.W. 2d 99 (TX, 1975), cert. den., 424 U.S. 954 (1976); and protect the public health as in the case of compulsory vaccination over the strongest of

religious objections, e.g., *Wright v. DeWitt School Dist. 1,* 385 S.W. 2d 644 (AR, 1965); *McCartney v. Austin,* 293 N.Y.S. 2d 188 (1968). The public interest is thus considered paramount, without essential dissolution of respect for religious beliefs.

We think . . . that, ranged against the state's interest in the preservation of life, the impingement of religious belief, much less religious *neutrality* as here, does not reflect a constitutional question, in the circumstances at least of the case presently before the court. Moreover, like the trial court, we do not recognize an independent parental right of religious freedom to support the relief requested.

B. Cruel and Unusual Punishment

Similarly inapplicable to the case before us is the Constitution's Eighth Amendment protection against cruel and unusual punishment which, as held by the trial court, is not relevant to situations other than the imposition of penal sanctions. . . .

. . .

So it is in the case of the unfortunate Karen Quinlan. Neither the state, nor the law, but the accident of fate and nature, has inflicted upon her conditions which though in essence cruel and most unusual, yet do not amount to *punishment* in any constitutional sense.

. . .

C. The Right of Privacy

. . .

It is the issue of the constitutional right of privacy that has given us most concern, in the exceptional circumstances of this case. Here a loving parent, *qua* parent and raising the rights of his incompetent and profoundly damaged daughter, probably irreversibly doomed to no more than a biologically vegetative remnant of life, is before the court. He seeks authorization to abandon specialized technological procedures which can only maintain for a time a body having no potential for resumption or continuance of other than a vegetative existence.

We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death. . . .

We have no hesitancy in deciding . . . that no external compelling interest of the state could compel Karen to endure the unendurable, only to vegetate a few measurable

months with no realistic possibility of returning to any semblance of cognitive or sapient life. We perceive no thread of logic distinguishing between such a choice on Karen's part and a similar choice which, under the evidence in this case, could be made by a competent patient terminally ill, riddled by cancer and suffering great pain; such a patient would not be resuscitated or put on a respirator . . . and *a fortiori* would not be kept *against his will* on a respirator.

Although the Constitution does not explicitly mention a right of privacy, Supreme Court decisions have recognized that a right of personal privacy exists and that certain areas of privacy are guaranteed under the Constitution. *Eisenstadt v. Baird*, 405 U.S. 438 (1972); and *Stanley v. Georgia,* 394 U.S. 557 (1969). The Court has interdicted judicial intrusion into many aspects of personal decision, sometimes basing this restraint upon the conception of a limitation of judicial interest and responsibility, such as with regard to contraception and its relationship to family life and decision. *Griswold v. Connecticut,* 381 U.S. 479 (1965).

The Court in *Griswold* found the unwritten constitutional right of privacy to exist in the penumbra of specific guarantees of the Bill of Rights "formed by emanations from those guarantees that help give them life and substance." *Id.* at 484. Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions. *Roe v. Wade*, 410 U.S. 113 (1973).

. . .

The claimed interests of the state in this case are essentially the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment. In this case the doctors say that removing Karen from the respirator will conflict with their professional judgment. The plaintiff answers that Karen's present treatment serves only a maintenance function; that the respirator cannot cure or improve her condition but at best can only prolong her inevitable slow deterioration and death; and that the interests of the patient, as seen by her surrogate, the guardian, must be evaluated by the court as predominant, even in the face of an opinion *contra* by the present attending physicians. Plaintiff's distinction is significant. The nature of Karen's care and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. We think that the state's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the state interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. . . .

Our affirmation of Karen's independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight. . . .

. . . The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them. It is for this reason that we determine that Karen's right of privacy may be asserted in her behalf, in this respect, by her guardian and family under the particular circumstances presented by this record.

. . .

D. The Medical Factor

Having declared the substantive legal basis upon which plaintiff's rights as representative of Karen must be deemed predicated, we face and respond to the assertion on behalf of defendants that our premise unwarrantably offends prevailing medical standards. . . .

. . .

. . . When does the institution of life-sustaining procedures, ordinarily mandatory, become the subject of medical discretion in the context of administration to persons *in extremis*? And when does the withdrawal of such procedures, from such persons already supported by them, come within the orbit of medical discretion? When does a determination as to either of the foregoing contingencies court the hazard of civil or criminal liability on the part of the physician or institution involved?

. . . The dilemma is there, it is real, it is constantly resolved in accepted medical practice without attention in the courts, it pervades the issues in the very case we here examine. . . .

Doctors, to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultation with other physicians, must guide their decision-making processes in providing care to their patient. The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is

there to remove it from the control of the medical profession and place it in the hands of the courts?

. . . Determinations as to these must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the Court has a non-delegable judicial responsibility.

Put in another way, the law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of. Where a Karen Quinlan, or a parent, or a doctor, or a hospital, or a state seeks the process and response of a court, it must answer with its most informed conception of justice in the previously unexplored circumstances presented to it. That is its obligation and we are here fulfilling it, for the actors and those having an interest in the matter should not go without remedy.

. . .

Under the law as it then stood, Judge Muir was correct in declining to authorize withdrawal of the respirator.

However, in relation to the matter of the declaratory relief sought by plaintiff as representative of Karen's interests, we are required to reevaluate the applicability of the medical standards projected in the court below. The question is whether there is such internal consistency and rationality in the application of such standards as should warrant their constituting an ineluctable bar to the effectuation of substantive relief for plaintiff at the hands of the court. We have concluded not.

In regard to the foregoing, it is pertinent that we consider the impact on the standards both of the civil and criminal law as to medical liability and the new technological means of sustaining life irreversibly damaged.

The modern proliferation of substantial malpractice litigation and the less frequent but even more unnerving possibility of criminal sanctions would seem, for it is beyond human nature to suppose otherwise, to have bearing on the practice and standards as they exist. The brooding presence of such possible liability, it was testified here, had no part in the decision of the treating physicians. As did Judge Muir, we afford this testimony full credence. But we cannot believe that the stated factor has not had a strong influence on the standards. . . . Moreover our attention is drawn . . . to the widening ambiguity of those standards themselves in their application to the medical problems we are discussing.

. . . [I]t is perfectly apparent from the testimony. . . that humane decisions against resuscitative or maintenance therapy are frequently a recognized *de facto* response in the medical world to the irreversible, terminal, pain-ridden patient,

especially with familial consent. And these cases, of course, are far short of *brain death.*

We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die; and that they have sometimes refused to treat the hopeless and dying as if they were curable. . . . We think these attitudes represent a balanced implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the whole Judeo-Christian tradition of regard for human life. . . .

. . .

[T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.

A technique aimed at the underlying difficulty (though in a somewhat broader context) is described by Dr. Karen Teel, a pediatrician and a director of pediatric education, who writes in the *Baylor Law Review* under the title "The Physician's Dilemma: A Doctor's View -- What The Law Should Be." Dr. Teel recalls:

> Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make. We are not always morally and legally authorized to make them. The physician is thereby assuming a civil and criminal liability that, as often as not, he does not even realize as a factor in his decision. . . .
>
> I suggest that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared. Many hospitals have established an ethics committee composed of physicians, social workers, attorneys, and theologians, which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers. Generally, the authority of these committees is primarily restricted to the hospital setting and their official status is more that of an advisory body than of an enforcing body.
>
> The concept of an ethics committee which has this kind of organization and is readily accessible to those persons rendering medical care to patients, would be, I think, the most promising direction for further study at this point. [This would allow] some much needed dialogue regarding

> these issues and [force] the point of exploring all of the options for a particular patient. It diffuses the responsibility for making these judgments. Many physicians, in many circumstances, would welcome this sharing of responsibility. I believe that such an entity could lend itself well to an assumption of a legal status which would allow courses of action not now undertaken because of the concern for liability. 27 *Baylor L. Rev.* 6, 8-9 (1975).

The most appealing factor in the technique suggested by Dr. Teel seems to us to be the diffusion of professional responsibility for decision, comparable in a way to the value of multi-judge courts in finally resolving on appeal difficult questions of law. . . . In the real world, and in relationship to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent.

We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome. . . . This is not to say that in the case of an otherwise justiciable controversy access to the courts would be foreclosed; we speak rather of a general practice and procedure.

. . . [W]e conclude that the state of the pertinent medical standards and practices which guided the attending physicians in this matter is not such as would justify this court in deeming itself bound or controlled thereby in responding to the case for declaratory relief established by the parties on the record before us.

D. Alleged Criminal Liability

Having concluded that there is a right of privacy that might permit termination of treatment in the circumstances of this case, we turn to consider the relationship of the exercise of that right to the criminal law. We are aware that such termination of treatment would accelerate Karen's death. . . . We conclude that there would be no criminal homicide in the circumstances of this case. We believe, first that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.

These conclusions rest upon definitional and constitutional bases. The termination of treatment pursuant to the right of privacy is, within the limitations of this case, *ipso facto* lawful. . . . Furthermore, the exercise of a constitutional right such as we have here found is protected from criminal prosecution. We do not question the state's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy. . . .

E. The Guardianship of the Person

. . .

. . . [W]e sense . . . that while Mr. Quinlan feels a natural grief, and understandably sorrows because of the tragedy which has befallen his daughter, his strength of purpose and character far outweighs these sentiments and qualifies him eminently for guardianship of the person as well as the property of his daughter. Hence, we discern no valid reason to overrule the statutory intendment of preference to the next-of-kin.

IV. Declaratory Relief

. . . Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital ethics committee or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn . . . without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others. We herewith specifically so hold.

V. Conclusion

We therefore remand this record to the trial court to implement (without further testimonial hearing) the following decisions:

1. To discharge, with the thanks of the court for his service, the present guardian of the person of Karen Quinlan, Thomas R. Curtin, Esquire, a member of the bar and an officer of the court.

2. To appoint Joseph Quinlan as guardian of the person of Karen Quinlan with full power to make decisions with regard to the identity of her treating physicians.

. . .

Modified and remanded.

ROE v. WADE

Supreme Court of the United States, 1973
410 U.S. 113

Opinion by Mr. Justice Blackmun.[53]

This Texas federal appeal and its Georgia companion, *Doe* v. *Bolton,* 410 U.S. 178 (1973), present constitutional challenges to state criminal abortion legislation. . . .

We forthwith acknowledge our awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion.

. . .

In addition, population growth, pollution, poverty, and racial overtones tend to complicate and not to simplify the problem.

Our task, of course, is to resolve the issue by constitutional measurement, free of emotion and of predilection. We seek earnestly to do this, and, because we do, we have inquired into, and in this opinion place some emphasis upon, medical and medical-legal history and what that history reveals about man's attitudes toward the abortion procedure over the centuries. We bear in mind, too, Mr. Justice Holmes' admonition in his now-vindicated dissent in *Lochner v. New York,* 198 U.S. 45, 76 (1905):

> The Constitution is made for people of fundamentally differing views, and the accident of our finding certain opinions natural and familiar or novel and even shocking ought not to conclude our judgment upon the question whether statutes embodying them conflict with the Constitution of the United States.

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[53] Added from the body of the case. Justice Blackmun delivered the opinion of the Court, in which Chief Justice Burger, Justice Douglas, Justice Brennan, Justice Stewart, Justice Marshall, and Mr. Justice Powell joined. Chief Justice Burger, Justice Douglas, and Justice Stewart each filed concurring opinions. Justice White filed a dissenting opinion, in which Justice Rehnquist joined; and Justice Rehnquist filed a separate dissenting opinion.

I. [Texas Law]

The Texas statutes that concern us here are Arts. 1191-1194 and 1196 of the Texas State Penal Code, . . . [hereinafter set forth.]

> Article 1191. Abortion
>
> If any person shall designedly administer to a pregnant woman or knowingly procure to be administered with her consent any drug or medicine, or shall use towards her any violence or means whatever externally or internally applied, and thereby procure an abortion, he shall be confined in the penitentiary not less than two nor more than five years; if it be done without her consent, the punishment shall be doubled. By *abortion* is means that the life of the fetus or embryo shall be destroyed in the woman's womb or that a premature birth thereof be caused.
>
> Article 1192. Furnishing the means
>
> Whoever furnishes the means for procuring an abortion knowing the purpose intended is guilty as an accomplice.
>
> Article 1193. Attempt at Abortion
>
> If the means used shall fail to produce an abortion, the offender is nevertheless guilty of an attempt to produce abortion, provided it be shown that such means were calculated to produce that result, and shall be fined not less than one hundred nor more than one thousand dollars.
>
> Article 1194. Murder in Producing Abortion
>
> If the death of the mother is occasioned by an abortion so produced or by an attempt to effect the same it is murder.
>
> Article 1195. Destroying Unborn Child
>
> Whoever shall during parturition of the mother destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive, shall be confined in the penitentiary for life or for not less than five years.
>
> Article 1196. By Medical Advice
>
> Nothing in this chapter applies to an abortion procured or attempted by medical advice for the purpose of saving the life of the mother.

These make it a crime to *procure an abortion*, as therein defined, or to attempt one, except with respect to "an abortion procured or attempted by medical advice for the purpose of saving the life of the mother." Similar statutes are in existence in a majority of the states.

. . .

II. Plaintiffs' Allegations

Jane Roe, [the name being a pseudonym,] a single woman who was residing in Dallas County, Texas, instituted this federal action in March 1970 against the District Attorney of [Dallas] County. She sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional on their face, and an injunction restraining the defendant from enforcing the statutes.

Roe alleged that she was unmarried and pregnant; that she wished to terminate her pregnancy by an abortion "performed by a competent, licensed physician, under safe, clinical conditions"; that she was unable to get a *legal* abortion in Texas because her life did not appear to be threatened by the continuation of her pregnancy; and that she could not afford to travel to another jurisdiction in order to secure a legal abortion under safe conditions. She claimed that the Texas statutes were unconstitutionally vague and that they abridged her right of personal privacy, protected by the First, Fourth, Fifth, Ninth, and Fourteenth Amendments. By an amendment to her complaint Roe purported to sue on behalf of herself and all other women similarly situated.

James Hubert Hallford, a licensed physician, sought and was granted leave to intervene in Roe's action. In his complaint he alleged that he had been arrested previously for violations of the Texas abortion statutes and that two such prosecutions were pending against him. He described conditions of patients who came to him seeking abortions, and he claimed that for many cases he, as a physician, was unable to determine whether they fell within or outside the exception recognized by Article 1196. He alleged that, as a consequence, the statutes were vague and uncertain, in violation of the Fourteenth Amendment, and that they violated his own and his patients' rights to privacy in the doctor-patient relationship and his own right to practice medicine, rights he claimed were guaranteed by the First, Fourth, Fifth, Ninth, and Fourteenth Amendments.

John and Mary Doe, a married couple, [the names being pseudonyms,] filed a companion complaint to that of Roe. They also named the district attorney as defendant, claimed like constitutional deprivations, and sought declaratory and injunctive relief. The Does alleged that they were a childless couple; that Mrs. Doe was suffering from a neural-chemical disorder; that her physician had "advised her to avoid pregnancy until such time as her condition has materially improved" (although a pregnancy at the present time would not present *a serious risk* to her life); that, pursuant to medical advice, she had discontinued use of birth control pills; and that if she should become pregnant, she would want to terminate the pregnancy by an abortion performed by a competent, licensed physician under safe, clinical conditions. By an amendment to their complaint, the Does purported to sue "on behalf of themselves and all couples similarly situated."

The two actions were consolidated and heard together. . . . The suits thus presented the situations of the pregnant single woman; the childless couple, with the wife not pregnant; and the licensed practicing physician, all joining in the attack on the Texas criminal abortion statutes. . . . [M]otions were made for dismissal and for summary judgment. The court held that Roe and members of her class, and Dr. Hallford, had standing to sue and presented justiciable controversies, but that the Does had failed to allege facts sufficient to state a present controversy and did not have standing. . . On the merits, the District Court held that the "fundamental right of single women and married persons to choose whether to have children is protected by the Ninth Amendment, through the Fourteenth Amendment," and that the Texas criminal abortion statutes were void on their face because they were both unconstitutionally vague and constituted an overbroad infringement of the plaintiffs' Ninth Amendment rights. . . .

. . . Both sides also have taken protective appeals to the United States Court of Appeals for the Fifth Circuit. That court ordered the appeals held in abeyance pending decision here. We [proceed to a hearing on the merits.]

. . .

III. - V. [omitted]

VI. [Historical Background]

The principal thrust of appellant's attack on the Texas statutes is that they improperly invade a right, said to be possessed by the pregnant woman, to choose to terminate her pregnancy. Appellant would discover this right in the concept of personal *liberty* embodied in the Fourteenth Amendment's Due Process Clause; or in personal, marital, familial, and sexual privacy said to be protected by the Bill of Rights or its penumbras, see *Griswold v. Connecticut,* 381 U.S. 479 (1965); and *Eisenstadt v. Baird,* 405 U.S. 438 (1972). Before addressing this claim, we feel it desirable briefly to survey, in several aspects, the history of abortion, for such insight as that history may afford us, and then to examine the state purposes and interests behind the criminal abortion laws.

It perhaps is not generally appreciated that the restrictive criminal abortion laws in effect in a majority of states today are of relatively recent vintage. Those laws, generally proscribing abortion or its attempt at any time during pregnancy except when necessary to preserve the pregnant woman's life, are not of ancient or even of common-law origin. Instead, they derive from statutory changes effected, for the most part, in the latter half of the 19th Century.

A. Ancient Attitudes

These are not capable of precise determination. We are told that at the time of the Persian Empire abortifacients were known and that criminal abortions were severely punished. We are also told, however, that abortion was practiced in Greek times as well as in the Roman Era, and that it was resorted to without scruple. The Ephesian, Soranos, often described as the greatest of the ancient gynecologists, appears to have been generally opposed to Rome's prevailing free-abortion practices. He found it necessary to think first of the life of the mother, and he resorted to abortion when, upon this standard, he felt the procedure advisable. Greek and Roman law afforded little protection to the unborn. If abortion was prosecuted in some places, it seems to have been based on a concept of a violation of the father's right to his offspring. Ancient religion did not bar abortion.[54]

B. The Hippocratic Oath[55]

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[54] Castiglioni, A History of Medicine 84 (2d ed. 1947), E. Krumbhaar, translator and editor (hereinafter Castiglioni); Edelstein, The Hippocratic Oath 10 (1943) (hereinafter Edelstein); and J. Ricci, The Genealogy of Gynaecology 52, 84, 113, 149 (2d ed. 1950) (hereinafter Ricci).

[55] Added. I swear by Apollo, the Physician, by Aesculapius and Hygeia and Panacea, and I take to witness all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

> To hold him who has taught me this art as equal to my parents and to live in common with him, and if he is in need of money or any thing to share what I have with him, and to regard his offspring as equal to my brothers in male lineage and to teach them this art -- if they desire to hear it -- without fee or written covenant; to impart to my sons and the sons of those who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and instructions.
>
> I will apply regimen for the benefit of the sick according to my ability and judgment and will never do harm or injustice to them.
>
> I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect Similarly, I will not give to a woman a pessary to procure abortion. In purity and holiness, I will guard my life and my art.
>
> I will not use the knife, not even on suffers from stone and even when the disease is manifest, but will withdraw in favor of such men as are engaged in this work.
>
> Whatever houses I may visit, I will come for the benefit of the sick remaining free of all intentional in justice, of all mischief, and in particular of sexual relations with both female and male persons, be they free or slave.
>
> What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things unspeakable to be spoken about.
>
> If I fulfill this oath and do not violate it, may it be granted to me to enjoy my life and art, being honored with fame among all men for all time to come; If I transgress it and swear falsely, may the opposite of all this be true.

. . . The Oath varies somewhat according to the particular translation, but in any translation the content is clear: "I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion," or "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy."

. . . Why did not the authority of Hippocrates dissuade abortion practice in his time and that of Rome? The late Dr. Edelstein provides us with a theory: The Oath was not uncontested even in Hippocrates' day; only the Pythagorean school of philosophers frowned upon the related act of suicide. Most Greek thinkers, on the other hand, commended abortion, at least prior to viability. See Plato, *Republic*, V, 461; Aristotle, *Politics*, VII, 1335b 25. For the Pythagoreans, however, it was a matter of dogma. For them the embryo was animate from the moment of conception, and abortion meant destruction of a living being. The abortion clause of the Oath, therefore, "echoes Pythagorean doctrines," and "in no other stratum of Greek opinion were such views held or proposed in the same spirit of uncompromising austerity." Edelstein 12 and 15-18.

Dr. Edelstein then concludes that the Oath originated in a group representing only a small segment of Greek opinion and that it certainly was not accepted by all ancient physicians. He points out that medical writings down to Galen (A. D. 130-200) "give evidence of the violation of almost every one of its injunctions." *Id.* at 18. But with the end of antiquity a decided change took place. Resistance against suicide and against abortion became common. The Oath came to be popular. The emerging teachings of Christianity were in agreement with the Pythagorean ethic. The Oath "became the nucleus of all medical ethics" and "was applauded as the embodiment of truth." Thus, suggests Dr. Edelstein, it is "a Pythagorean manifesto and not the expression of an absolute standard of medical conduct." *Id.* at 63.

This, it seems to us, is a satisfactory and acceptable explanation of the Hippocratic Oath's apparent rigidity. It enables us to understand, in historical context, a long-accepted and revered statement of medical ethics.

C. The Common Law

It is undisputed that at common law, abortion performed *before quickening* -- the first recognizable movement of the fetus *in utero*, appearing usually from the 16th to the 18th week of pregnancy -- was not an indictable offense. The absence of a common-law crime for pre-quickening abortion appears to have developed from a confluence of earlier philosophical, theological, and civil and canon law concepts of when life begins. These disciplines variously approached the question in terms of the point at which the embryo or fetus became *formed* or recognizably human, or in terms of when a *person* came into being, that is, became infused with a *soul* or *animated.* A loose consensus evolved in early English law that these events occurred at some point between conception and live birth. This was *mediate animation.* Although Christian theology

and the canon law came to fix the point of animation at 40 days for a male and 80 days for a female, [56]a view that persisted until the 19th Century, there was otherwise little agreement about the precise time of formation or animation. There was agreement, however, that prior to this point the fetus was to be regarded as part of the mother, and its destruction, therefore, was not homicide. . . . The significance of quickening was echoed by later common-law scholars and found its way into the received common law in this country.

Whether abortion of a *quick* fetus was a felony at common law, or even a lesser crime, is still disputed. Bracton, writing early in the 13th Century, thought it homicide. 2 H. Bracton, *De Legibus et Consuetudinibus Angliae* 279 (T. Twiss ed. 1879). But the later and predominant view, following the great common-law scholars, has been that it was, at most, a lesser offense. In a frequently cited passage, Coke took the position that abortion of a woman *quick with child* is "a great misprision, and no murder." E. Coke, *Institutes* III 50. Blackstone followed, *Commentaries*, 129-130, saying that while abortion after quickening had once been considered manslaughter (though not murder), modern law took a less severe view. A recent review of the common-law precedents argues, however, that those precedents contradict Coke and that even post-quickening abortion was never established as a common-law crime. This is of some importance because while most American courts ruled, in holding or dictum, that abortion of an unquickened fetus was not criminal under their received common law,[57] others followed

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[56] Early philosophers believed that the embryo or fetus did not become formed and begin to live until at least 40 days after conception for a male, and 80 to 90 days for a female. See, for example, Aristotle, *Hist. Anim.* 7.3.583b; *Gen. Anim.* 2.3.736, 2.5.741; Hippocrates, *Lib. de Nat. Puer.*, No. 10. Aristotle's thinking derived from his three-stage theory of life: vegetable, animal, rational. The vegetable stage was reached at conception, the animal at *animation*, and the rational soon after live birth. This theory, together with the 40/80 day view, came to be accepted by early Christian thinkers.

The theological debate was reflected in the writings of St. Augustine, who made a distinction between *embryo inanimatus*, not yet endowed with a soul, and *embryo animatus*. He may have drawn upon *Exodus* 21:22, [the verse dealing with a man who, fighting with another, strikes a woman and causes an abortion.] At one point, however, he expressed the view that human powers cannot determine the point during fetal development at which the critical change occurs. See Augustine, *De Origine Animae* 4.4 (Pub. Law 44.527). See also W. Reany, *The Creation of the Human Soul,* c. 2 and 83-86 (1932); Huser, *The Crime of Abortion in Canon Law* 15 (Catholic Univ. of America, Canon Law Studies No. 162, Washington, D. C., 1942).

Galen, in three treatises related to embryology, accepted the thinking of Aristotle and his followers. Quay 426-427. Later, Augustine on abortion was incorporated by Gratian into the *Decretum*, published about 1140. *Decretum Magistri Gratiani* 2.32.2.7 to 2.32.2.10, in 1 *Corpus Juris Canonici* 1122, 1123 (A. Friedburg, 2d ed. 1879). This Decretal and the Decretals that followed were recognized as the definitive body of canon law until the new Code of 1917.

For discussions of the canon law treatment, see Means, *The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality* (pt. 1), 14 N. Y. L. F. 411, 411-412 (1968) (hereinafter Means I); Noonan 20-26; Quay 426-430; see also J. Noonan, *Contraception: A History of Its Treatment by the Catholic Theologians and Canonists* 18-29 (1965).

[57] *Commonwealth v. Bangs,* 9 Mass. 387 (1812); *Commonwealth v. Parker*, 50 Mass. 263, (1845); *State v. Cooper,* 22 N. J. L. 52 (1849); *Abrams v. Foshee,* 3 Iowa 274 (1856); *Smith v. Gaffard,* 31 Ala. 45 (1857); *Mitchell v. Commonwealth,* 78 Ky. 204 (1879); *Eggart v. State,* 25 So. 144 (FL, 1898); *State v.*

Coke in stating that abortion of a quick fetus was a *misprision,* a term they translated to mean *misdemeanor*. . . .[58] [I]t now appear[s] doubtful that abortion was ever firmly established as a common-law crime even with respect to the destruction of a quick fetus.

D. The English Statutory Law

England's first criminal abortion statute, Lord Ellenborough's Act, 43 Geo. 3, c. 58, came in 1803. It made abortion of a quick fetus, §1, a capital crime, but in §2 it provided lesser penalties for the felony of abortion before quickening, and thus preserved the quickening distinction. This contrast was continued in the general revision of 1828, *9 Geo. 4,* c. 31, §13. It disappeared, however, together with the death penalty, in 1837, 7 Will. 4 & 1 Vict., c. 85, §6, and did not reappear in the Offenses Against the Person Act of 1861, 24 & 25 Vict., c. 100, §59, that formed the core of English anti-abortion law until the liberalizing reforms of 1967. In 1929, the Infant Life (Preservation) Act came into being. Its emphasis was upon the destruction of "the life of a child capable of being born alive." It made a willful act performed with the necessary intent a felony. It contained a proviso that one was not to be found guilty of the offense "unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother." 19 & 20 Geo. 5, c. 34.

A seemingly notable development in the English law was the case of *Rex v. Bourne,* 1 K. B. 687 (1939). This case apparently answered in the affirmative the question whether an abortion necessary to preserve the life of the pregnant woman was excepted from the criminal penalties of the 1861 Act. He then construed the phrase "preserving the life of the mother" broadly, that is, "in a reasonable sense," to include a serious and permanent threat to the mother's *health,* and instructed the jury to acquit Dr. Bourne if it found he had acted in a good-faith belief that the abortion was necessary for this purpose. *Id.* at 693-694. The jury did acquit.

Recently, Parliament enacted a new abortion law. This is the Abortion Act of 1967, 15 & 16 Eliz. 2, c. 87. The Act permits a licensed physician to perform an abortion where two other licensed physicians agree (a) "that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated," or (b) ". . . a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped." The Act also provides that, in making this determination, "account may be taken of the pregnant woman's actual or reasonably foreseeable environment." It also permits a physician, without the concurrence of others, to

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Alcorn, 64 P. 1014 (ID, 1901); *Edwards v. State,* 112 N. W. 611 (NE, 1907); *Gray v. State,* 178 S. W. 337 (TX, 1915); and *Miller v. Bennett,* 56 S. E. 2d 217 (VA, 1949).

[58] See *Smith v. State,* 33 Me. 48 (1851); *Evans v. People,* 49 N. Y. 86 (1872); and *Lamb v. State,* 10 A. 208 (MD, 1887).

terminate a pregnancy where he is of the good-faith opinion that the abortion "is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman."

E. The American Law

In this country, the law in effect in all but a few states until mid-19th Century was the pre-existing English common law. Connecticut, the first state to enact abortion legislation, adopted in 1821 that part of Lord Ellenborough's Act that related to a woman *quick* with child. The death penalty was not imposed. Abortion before quickening was made a crime in that state only in 1860. In 1828, New York enacted legislation that, in two respects, was to serve as a model for early anti-abortion statutes. First, while barring destruction of an unquickened fetus as well as a quick fetus, it made the former only a misdemeanor, but the latter second-degree manslaughter. Second, it incorporated a concept of therapeutic abortion by providing that an abortion was excused if it "shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose." By 1840, when Texas had received the common law, only eight American states had statutes dealing with abortion. It was not until after the War Between the States that legislation began generally to replace the common law. Most of these initial statutes dealt severely with abortion after quickening but were lenient with it before quickening. Most punished attempts equally with completed abortions. While many statutes included the exception for an abortion thought by one or more physicians to be necessary to save the mother's life, that provision soon disappeared and the typical law required that the procedure actually be necessary for that purpose.

Gradually, in the middle and late 19th Century the quickening distinction disappeared from the statutory law of most states and the degree of the offense and the penalties were increased. By the end of the 1950s, a large majority of the jurisdictions banned abortion, however and whenever performed, unless done to save or preserve the life of the mother. The exceptions, Alabama and the District of Columbia, permitted abortion to preserve the mother's health. Three states [Massachusetts, New Jersey, and Pennsylvania] permitted abortions that were not *unlawfully* performed or that were not *without lawful justification*, leaving interpretation of those standards to the courts. In the past several years, however, a trend toward liberalization of abortion statutes has resulted in adoption, by about one-third of the states, of less stringent laws, most of them patterned after the American Law Institute's Model Penal Code, §230.3. . . .

It is thus apparent that at common law, at the time of the adoption of our Constitution, and throughout the major portion of the 19th Century, abortion was viewed with less disfavor than under most American statutes currently in effect. Phrasing it another way, a woman enjoyed a substantially broader right to terminate a pregnancy than she does in most states today. At least with respect to the early stage of pregnancy, and very possibly without such a limitation, the opportunity to make this

choice was present in this country well into the 19th Century. Even later, the law continued for some time to treat less punitively an abortion procured in early pregnancy.

F. The Position of the American Medical Association (AMA)

The anti-abortion mood prevalent in this country in the late 19th Century was shared by the medical profession. Indeed, the attitude of the profession may have played a significant role in the enactment of stringent criminal abortion legislation during that period.

An AMA Committee on Criminal Abortion was appointed in May 1857. It presented its report, 12 *Trans. of the American Medical Association* 73-78 (1859), to the Twelfth Annual Meeting. That report observed that the committee had been appointed to investigate criminal abortion "with a view to its general suppression." It deplored abortion and its frequency and it listed three causes of "this general demoralization":

> The first of these causes is a wide-spread popular ignorance of the true character of the crime -- a belief, even among mothers themselves, that the foetus is not alive till after the period of quickening.
>
> The second of the agents alluded to is the fact that the profession themselves are frequently supposed[ly] careless of foetal life . . . .
>
> The third reason of the frightful extent of this crime is found in the grave defects of our laws, both common and statute, as regards the independent and actual existence of the child before birth, as a living being. These errors, which are sufficient in most instances to prevent conviction, are based, and only based, upon mistaken and exploded medical dogmas. With strange inconsistency, the law fully acknowledges the foetus in utero and its inherent rights, for civil purposes; while personally and as criminally affected, it fails to recognize it, and to its life as yet denies all protection." *Id.* at 75-76. . . .

In 1871, a long and vivid report was submitted by the Committee on Criminal Abortion. . . . It proffered resolutions, adopted by the AMA, recommending, among other things, that it "be unlawful and unprofessional for any physician to induce abortion or premature labor, without the concurrent opinion of at least one respectable consulting physician, and then always with a view to the safety of the child -- if that be possible," and calling "the attention of the clergy of all denominations to the perverted views of morality entertained by a large class of females -- aye, and men also, on this important question." 22 *Trans. of the American Medical Association* 258 (1871).

Except for periodic condemnation of the criminal abortionist, no further formal AMA action took place until 1967. In that year, the Committee on Human Reproduction urged the adoption of a stated policy of opposition to induced abortion,

except when there is "documented medical evidence" of a threat to the health or life of the mother, or that the child "may be born with incapacitating physical deformity or mental deficiency," or that a pregnancy "resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient," two other physicians "chosen because of their recognized professional competence have examined the patient and have concurred in writing," and the procedure "is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals." The providing of medical information by physicians to state legislatures in their consideration of legislation regarding therapeutic abortion was "to be considered consistent with the principles of ethics of the AMA." This recommendation was adopted by the House of Delegates. *Proceedings of the AMA House of Delegates* 40-51 (June 1967).

In 1970, after the introduction of a variety of proposed resolutions, and of a report from its Board of Trustees, a reference committee noted "polarization of the medical profession on this controversial issue"; division among those who had testified; a difference of opinion among AMA councils and committees; "the remarkable shift in testimony" in six months, felt to be influenced "by the rapid changes in state laws and by the judicial decisions which tend to make abortion more freely available;" and a feeling "that this trend will continue." On June 25, 1970, the AMA House of Delegates adopted preambles and most of the resolutions proposed by the reference committee. The preambles emphasized *the best interests of the patient*, sound clinical judgment, and *informed patient consent*, in contrast to mere acquiescence to the patient's demand. The resolutions asserted that abortion is a medical procedure that should be performed by a licensed physician in an accredited hospital only after consultation with two other physicians and in conformity with state law, and that no party to the procedure should be required to violate personally held moral principles. --Proceedings of the AMA House of Delegates 220 (June 1970). The AMA Judicial Council rendered a complementary opinion.

G. The Position of the American Public Health Association (APHA)

In October 1970, the Executive Board of the APHA adopted Standards for Abortion Services, "Recommended Standards for Abortion Services," 61 *Am. J. Pub. Health* 396 (1971). These were five in number:

> a. Rapid and simple abortion referral must be readily available through state and local public health departments, medical societies, or other nonprofit organizations.
>
> b. An important function of counseling should be to simplify and expedite the provision of abortion services; it should not delay the obtaining of these services.

c. Psychiatric consultation should not be mandatory. As in the case of other specialized medical services, psychiatric consultation should be sought for definite indications and not on a routine basis.

d. A wide range of individuals from appropriately trained, sympathetic volunteers to highly skilled physicians may qualify as abortion counselors.

e. Contraception and/or sterilization should be discussed with each abortion patient.

. . .

H. The Position of the American Bar Association (ABA)

At its meeting in February 1972 the ABA House of Delegates approved, with 17 opposing votes, the Uniform Abortion Act . . . [of] the Conference of Commissioners on Uniform State Laws. *58 A. B. A. Journal* 380 (1972). . . .

UNIFORM ABORTION ACT

SECTION 1. [*Abortion Defined; When Authorized.*]

(a) *Abortion* means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

(b) An abortion may be performed in this state only if it is performed:

(1) by a physician licensed to practice medicine or osteopathy in this state or by a physician practicing medicine or osteopathy in the employ of the government of the United States or of this state,[and the abortion is performed in the physician's office or in a medical clinic, or in a hospital approved by the Department of Health or operated by the United States, this state, or any department, agency, or political subdivision of either; or by a female upon herself upon the advice of the physician; an

(2) within 20 weeks after the commencement of the pregnancy or after 20 weeks only if the physician has reasonable cause to believe (i) there is a substantial risk that continuance of the pregnancy would endanger the life of the mother or would gravely impair the physical or mental health of the mother, (ii) that the child would be born with grave physical or mental defect, or (iii) that the pregnancy resulted from rape or incest, or illicit intercourse with a girl under the age of 16 years.

. . .

VII. [Reasons for Abortion Laws]

Three reasons have been advanced to explain historically the enactment of criminal abortion laws in the 19th Century and to justify their continued existence.

It has been argued occasionally that these laws were the product of a Victorian social concern to discourage illicit sexual conduct. Texas, however, does not advance this justification in the present case, and it appears that no court or commentator has taken the argument seriously. . . .

A second reason is concerned with abortion as a medical procedure. When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman. This was particularly true prior to the development of antisepsis. Antiseptic techniques, of course, were based on discoveries by Lister, Pasteur, and others first announced in 1867, but were not generally accepted and employed until about the turn of the century. Abortion mortality was high. Even after 1900, and perhaps until as late as the development of antibiotics in the 1940s, standard modern techniques such as dilation and curettage were not nearly so safe as they are today. Thus, it has been argued that a state's real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy.

Modern medical techniques have altered this situation. Appellants and various *amici* refer to medical data indicating that abortion in early pregnancy, that is, prior to the end of the first trimester, although not without its risk, is now relatively safe. Mortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low as or lower than the rates for normal childbirth. Consequently, any interest of the state in protecting the woman from an inherently hazardous procedure, except when it would be equally dangerous for her to forgo it, has largely disappeared. Of course, important state interests in the areas of health and medical standards do remain. The state has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise. The prevalence of high mortality rates at illegal *abortion mills* strengthens, rather than weakens, the state's interest in regulating the conditions under which abortions are performed. Moreover, the risk to the woman increases as her pregnancy continues. Thus, the state retains a definite interest in protecting the woman's own health and safety when an abortion is proposed at a late stage of pregnancy.

The third reason is the state's interest -- some phrase it in terms of duty -- in protecting prenatal life. Some of the argument for this justification rests on the theory that a new human life is present from the moment of conception. The state's interest and general obligation to protect life then extends, it is argued, to prenatal life. Only when

the life of the pregnant mother herself is at stake, balanced against the life she carries within her, should the interest of the embryo or fetus not prevail. Logically, of course, a legitimate state interest in this area need not stand or fall on acceptance of the belief that life begins at conception or at some other point prior to live birth. In assessing the state's interest, recognition may be given to the less rigid claim that as long as at least *potential* life is involved, the state may assert interests beyond the protection of the pregnant woman alone.

Parties challenging state abortion laws have sharply disputed in some courts the contention that a purpose of these laws, when enacted, was to protect prenatal life. Pointing to the absence of legislative history to support the contention, they claim that most state laws were designed solely to protect the woman. . . . There is some scholarly support for this view of original purpose. The few state courts called upon to interpret their laws in the late 19th and early 20th Centuries did focus on the state's interest in protecting the woman's health rather than in preserving the embryo and fetus. Proponents of this view point out that in many states, including Texas, by statute or judicial interpretation, the pregnant woman herself could not be prosecuted for self-abortion or for cooperating in an abortion performed upon her by another. They claim that adoption of the *quickening* distinction through received common law and state statutes tacitly recognizes the greater health hazards inherent in late abortion and impliedly repudiates the theory that life begins at conception.

It is with these interests, and the weight to be attached to them, that this case is concerned.

VIII. [Discussion of the Right of Privacy]

The Constitution does not explicitly mention any right of privacy. In a line of decisions, however, going back perhaps as far as *Union Pacific R. Co.* v. *Botsford,* 141 U.S. 250 (1891), the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. In varying contexts, the Court or individual Justices have, indeed, found at least the roots of that right in the First Amendment, *Stanley v. Georgia,* 394 U.S. 557 (1969); in the Fourth and Fifth Amendments, *Terry v. Ohio,* 392 U.S. 1 (1968), *Katz v. United States,* 389 U.S. 347 (1967), *Boyd v. United States,* 116 U.S. 616 (1886); in the penumbras of the Bill of Rights and the Ninth Amendment, *Griswold v. Connecticut,* 381 U.S. (1965); or in the concept of liberty guaranteed by the first section of the Fourteenth Amendment, see *Meyer v. Nebraska,* 262 U.S. 390 (1923). These decisions make it clear that only personal rights that can be deemed *fundamental* or "implicit in the concept of ordered liberty," *Palko v. Connecticut,* 302 U.S. 319, 325 (1937), are included in this guarantee of personal privacy. They also make it clear that the right has some extension to activities relating to marriage, *Loving v. Virginia,* 388 U.S. 1 (1967); procreation, *Skinner v. Oklahoma,* 316 U.S. 535 (1942); contraception, *Eisenstadt v. Baird,* 405 U.S. 438 (1972); family relationships, *Prince v. Massachusetts,* 321 U.S. 158 (1944); and child rearing and education, *Pierce v. Society of Sisters,* 268 U.S. 510 (1925).

This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The detriment that the state would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

On the basis of elements such as these, appellant and some *amici* argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree. Appellant's arguments that Texas either has no valid interest at all in regulating the abortion decision, or no interest strong enough to support any limitation upon the woman's sole determination, are unpersuasive. The Court's decisions recognizing a right of privacy also acknowledge that some state regulation in areas protected by that right is appropriate. As noted above, a state may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these respective interests become sufficiently compelling to sustain regulation of the factors that govern the abortion decision. The privacy right involved, therefore, cannot be said to be absolute. In fact, . . .[t]he 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.

We, therefore, conclude that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation.

. . .

IX. [Discussion]

. . .

A. [Status of the Fetus]

The appellee and certain *amici* argue that the fetus is a *person* within the language and meaning of the Fourteenth Amendment. In support of this, they outline at length and in detail the well-known facts of fetal development. If this suggestion of personhood is established, the appellant's case, of course, collapses, for the fetus' right

to life would then be guaranteed specifically by the Amendment . . . On the other hand, the appellee conceded on reargument that no case could be cited that holds that a fetus is a person within the meaning of the Fourteenth Amendment.

The Constitution does not define *person* in so many words. Section 1 of the Fourteenth Amendment contains three references to *person.*[59] The first, in defining *citizens*, speaks of "persons born or naturalized in the United States." The word also appears both in the Due Process Clause and in the Equal Protection Clause. *Person* is used in other places in the Constitution: in the listing of qualifications for Representatives and Senators, Art. I, §2, cl. 2, and §3, cl. 3; in the Apportionment Clause, Article I, §2, cl. 3; in the Migration and Importation provision, Article I, §9, cl. 1; in the Emolument Clause, Article I, §9, cl. 8; in the Electors provisions, Article II, §1, cl. 2, and the superseded clause. 3; in the provision outlining qualifications for the office of President, Article. II, §1, cl. 5; in the Extradition provisions, Article IV, §2, cl. 2, and the superseded Fugitive Slave clause 3; and in the Fifth, Twelfth, and Twenty-Second Amendments, as well as in §2 and §3 of the Fourteenth Amendment. But in nearly all these instances, the use of the word is such that it has application only postnatally. None indicates, with any assurance, that it has any possible pre-natal application.

All this, together with our observation, *supra*, that throughout the major portion of the 19th Century prevailing legal abortion practices were far freer than they are today, persuades us that the word *person*, as used in the Fourteenth Amendment, does not include the unborn. This is in accord with the results reached in those few cases where the issue has been squarely presented. *McGarvey v. Magee-Womens Hospital*, 340 F.Supp. 751 (1972); *Byrn v. New York City Health & Hospitals Corp.*, 286 N. E. 2d 887 (NY, 1972), appeal docketed, No. 72-434; *Abele v. Markle*, 351 F.Supp. 224 (1972), appeal docketed, No. 72-730. Indeed, our decision in *United States v. Vuitch*, 402 U.S. 62 (1971), inferentially is to the same effect, for we there would not have indulged in statutory interpretation favorable to abortion in specified circumstances if the necessary consequence was the termination of life entitled to Fourteenth Amendment protection.

This conclusion, however, does not of itself fully answer the contentions raised by Texas, and we pass on to other considerations.

B. [Privacy Rights]

The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young in the human uterus. . . . The situation therefore is inherently different from marital intimacy, or bedroom possession of obscene material, or marriage, or procreation, or education,

[59] Added. Amendment 14, Section 1: All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws. [Emphasis added.]

with which *Eisenstadt* and *Griswold, Stanley, Loving, Skinner*, and *Pierce* and *Meyer* were respectively concerned. As we have intimated above, it is reasonable and appropriate for a state to decide that at some point in time another interest, that of health of the mother or that of potential human life, becomes significantly involved. The woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly.

Texas urges that, apart from the Fourteenth Amendment, life begins at conception and is present throughout pregnancy, and that, therefore, the state has a compelling interest in protecting that life from and after conception. We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.

It should be sufficient to note briefly the wide divergence of thinking on this most sensitive and difficult question. There has always been strong support for the view that life does not begin until live birth. This was the belief of the Stoics. It appears to be the predominant, though not the unanimous, attitude of the Jewish faith. It may be taken to represent also the position of a large segment of the Protestant community, insofar as that can be ascertained; organized groups that have taken a formal position on the abortion issue have generally regarded abortion as a matter for the conscience of the individual and her family. As we have noted, the common law found greater significance in quickening. Physicians and their scientific colleagues have regarded that event with less interest and have tended to focus either upon conception, upon live birth, or upon the interim point at which the fetus becomes *viable*, that is, potentially able to live outside the mother's womb, albeit with artificial aid. Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks. The Aristotelian theory of *mediate animation*, that held sway throughout the Middle Ages and the Renaissance in Europe, continued to be official Roman Catholic dogma until the 19th Century, despite opposition to this *ensoulment* theory from those in the Church who would recognize the existence of life from the moment of conception. The latter is now, of course, the official belief of the Catholic Church. As one brief *amicus* discloses, this is a view strongly held by many non-Catholics as well, and by many physicians. Substantial problems for precise definition of this view are posed, however, by new embryological data that purport to indicate that conception is a *process* over time, rather than an event, and by new medical techniques such as menstrual extraction, the *morning-after* pill, implantation of embryos, artificial insemination, and even artificial wombs.

In areas other than criminal abortion, the law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth. For example, the traditional rule of tort law denied recovery for prenatal injuries even though the child was born alive. That rule has been changed

in almost every jurisdiction. In most states, recovery is said to be permitted only if the fetus was viable, or at least quick, when the injuries were sustained, though few courts have squarely so held. In a recent development, generally opposed by the commentators, some states permit the parents of a stillborn child to maintain an action for wrongful death because of prenatal injuries. Such an action, however, would appear to be one to vindicate the parents' interest and is thus consistent with the view that the fetus, at most, represents only the potentiality of life. Similarly, unborn children have been recognized as acquiring rights or interests by way of inheritance or other devolution of property, and have been represented by guardians *ad litem*. Perfection of the interests involved, again, has generally been contingent upon live birth. In short, the unborn have never been recognized in the law as persons in the whole sense.

X. [Conclusion]

In view of all this, we do not agree that, by adopting one theory of life, Texas may override the rights of the pregnant woman that are at stake. We repeat, however, that the state does have an important and legitimate interest in preserving and protecting the health of the pregnant woman, whether she be a resident of the state or a nonresident who seeks medical consultation and treatment there, and that it has still *another* important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes *compelling*.

With respect to the state's important and legitimate interest in the health of the mother, the *compelling* point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now-established medical fact, referred to above, that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

This means, on the other hand, that, for the period of pregnancy prior to this *compelling* point, the attending physician, in consultation with his patient, is free to determine, without regulation by the state, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the state.

With respect to the state's important and legitimate interest in potential life, the *compelling* point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of

fetal life after viability thus has both logical and biological justifications. If the state is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother.

Measured against these standards, Article 1196 of the Texas Penal Code, in restricting legal abortions to those "procured or attempted by medical advice for the purpose of saving the life of the mother," sweeps too broadly. The statute makes no distinction between abortions performed early in pregnancy and those performed later, and it limits to a single reason, *saving* the mother's life, the legal justification for the procedure. The statute, therefore, cannot survive the constitutional attack made upon it here.

XI. [Summary]

To summarize and to repeat:

A state criminal abortion statute of the current Texas type, that excepts from criminality only a *lifesaving* procedure on behalf of the mother, without regard to pregnancy stage and without recognition of the other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment.

(a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.

(b) For the stage subsequent to approximately the end of the first trimester, the state, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

(c) For the stage subsequent to viability, the state in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

. . .

This holding, we feel, is consistent with the relative weights of the respective interests involved, with the lessons and examples of medical and legal history, with the lenity of the common law, and with the demands of the profound problems of the present day. The decision leaves the state free to place increasing restrictions on abortion as the period of pregnancy lengthens, so long as those restrictions are tailored to the recognized state interests. The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points

where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available.

XII. [Conclusion]

Our conclusion that Article 1196 is unconstitutional means, of course, that the Texas abortion statutes, as a unit, must fall. . . .

. . .

SCHLOENDORFF v. THE SOCIETY OF THE NEW YORK HOSPITAL

Court of Appeals of New York, 1914
105 N.E. 92

Cardozo, Judge.

In the year 1771, by royal charter of George III., the Society of the New York Hospital was organized for the care and healing of the sick. During the century and more which has since passed, it has devoted itself to that high task. It has no capital stock; it does not distribute profits; and its physicians and surgeons, both the visiting and the resident staff, serve it without pay. Those who seek it in search of health are charged nothing, if they are needy, either for board or for treatment. The well-to-do are required by its by-laws to pay $ 7 a week for board, an amount insufficient to cover the per capita cost of maintenance. . . . The purpose is not profit, but charity, and the incidental revenue does not change the defendant's standing as charitable institution

To this hospital the plaintiff came in January, 1908. She was suffering from some disorder of the stomach. She asked the superintendent or one of his assistants what the charge would be and was told that it would be $ 7 a week. She became an inmate of the hospital, and after some weeks of treatment the house physician, Dr. Bartlett, discovered a lump, which proved to be a fibroid tumor. He consulted the visiting surgeon, Dr. Stimson, who advised an operation. The plaintiff's testimony is that the character of the lump could not, so the physicians informed her, be determined without an ether examination. She consented to such an examination, but notified Dr. Bartlett, as she says, that there must be no operation. She was taken at night from the medical to the surgical ward and prepared for an operation by a nurse. On the following day, ether was administered and, while she was unconscious, a tumor was removed. Her testimony is that this was done without her consent or knowledge. She is contradicted both by Dr. Stimson and by Dr. Bartlett, as well as by many of the attendant nurses. For the purpose of this appeal, however, since a verdict was directed in favor of the defendant, her narrative, even if improbable, must be taken as true. Following the operation, and, according to the testimony of her witnesses, because of it, gangrene developed in her left arm; some of her fingers had to be amputated; and her sufferings were intense. She now seeks to charge the hospital with liability for the wrong.

Certain principles of law governing the rights and duties of hospitals when maintained as charitable institutions have, after much discussion, become no longer doubtful. It is the settled rule that such a hospital is not liable for the negligence of its physicians and nurses in the treatment of patients.[60] This exemption has been placed

[60] Added. This rule, called *charitable immunity*, has generally been abrogated; however, vestiges of it remain. By case law in some states, a cap is imposed upon damages that can be awarded against a charitable institution.

upon two grounds. The first is that of implied waiver. It is said that one who accepts the benefit of a charity enters into a relation which exempts one's benefactor from liability for the negligence of his servants in administering the charity. *Hordern v. Salvation Army*, 199 N.Y. 233 (1910). The hospital remains exempt though the patient makes some payment to help defray the cost of board. *Collins v. N. Y. Post Graduate Medical School and Hospital,* 59 App. Div. 63 (1908); *McDonald v. Massachusetts General Hospital*, 120 Mass. 432 (1876); *Downes v. Harper Hospital*, 101 Mich. 555 (1894); *Powers v. Massachusetts Homeopathic Hospital,* 109 F. 294 (1901). Such a payment is regarded as a contribution to the income of the hospital to be devoted, like its other funds, to the maintenance of the charity. The second ground of the exemption is the relation subsisting between a hospital and the physicians who serve it. It is said that this relation is not one of master and servant, but that the physician occupies the position, so to speak, of an independent contractor, following a separate calling, liable, of course, for his own wrongs to the patient whom he undertakes to serve, but involving the hospital in no liability if due care has been taken in his selection. On one or the other, and often on both of these grounds, a hospital has been held immune from liability to patients for the malpractice of its physicians. . . .

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every 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,[61] for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained. . . . In such circumstances the hospital's exemption from liability can hardly rest upon implied waiver. Relative to this transaction, the plaintiff was a stranger. She had never consented to become a patient for any purpose other than an examination under ether. She had never waived the right to recover damages for any wrong resulting from this operation, for she had forbidden the operation. In this situation, the true ground for the defendant's exemption from liability is that the relation between a hospital and its physicians is not that of master and servant. The hospital does not undertake to act through them, but merely to procure them to act upon their own responsibility. . . .

The defendant undertook to procure for this plaintiff the services of a physician. It did procure them. It procured the services of Dr. Bartlett and Dr. Stimson. One or both of those physicians (if we are to credit the plaintiff's narrative) ordered that an operation be performed on her in disregard of her instructions. The administrative staff of the hospital believing in good faith that the order was a proper one, and without notice to the contrary, gave to the operating surgeons the facilities of the surgical ward. The operation was then performed. The wrong was not that of the hospital; it was that of physicians, who were not the defendant's servants, but were pursuing an independent calling, a profession sanctioned by a solemn oath, and safeguarded by stringent penalties. If, in serving their patient, they violated her commands, the responsibility is

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[61] Added. Today, this (an unconsented touching) would be classified as a battery, not an assault.

not the defendant's; it is theirs. There is no distinction in that respect between the visiting and the resident physicians. *Hillyer v. St. Bartholomew's Hospital*, 2 K.B. 820 (1909). Whether the hospital undertakes to procure a physician from afar, or to have one on the spot, its liability remains the same.

I have said that the hospital supplied its facilities to the surgeons without notice that they contemplated a wrong. I think this is clearly true. The suggestion is made that notice may be gathered from two circumstances: from the plaintiff's statement to one or more of the nurses, and from her statement to the assistant administering the gas. To that suggestion I cannot yield my assent.

It is true, I think, of nurses as of physicians, that in treating a patient they are not acting as the servants of the hospital. The superintendent is a servant of the hospital; the assistant superintendents, the orderlies, and the other members of the administrative staff are servants of the hospital. But nurses are employed to carry out the orders of the physicians, to whose authority they are subject.[62] The hospital undertakes to procure for the patient the services of a nurse. It does not undertake through the agency of nurses to render those services itself. . . . If there are duties performed by nurses foreign to their duties in carrying out the physician's orders, and having relation to the administrative conduct of the hospital, the fact is not established by this record, nor was it in the discharge of such duties that the defendant's nurses were then serving. The acts of preparation immediately preceding the operation are necessary to its successful performance and are really part of the operation itself. They are not different in that respect from the administration of the ether. Whatever the nurse does in those preliminary stages is done, not as the servant of the hospital, but in the course of the treatment of the patient, as the delegate of the surgeon to whose orders she is subject. The hospital is not chargeable with her knowledge that the operation is improper any more than with the surgeon's.

If, however, it could be assumed that a nurse is a servant of the hospital, I do not think that anything said by the plaintiff to any of the defendant's nurses fairly gave notice to them that the purpose was to cut open the plaintiff's body without her consent. The visiting surgeon in charge of the case was one of the most eminent in the city of New York. The assistant physicians and surgeons were men of tested merit. The plaintiff was prepared for the operation at night. She said to the night nurse, according to her statement, that she was not going to be operated on, that she was merely going to be examined under the influence of ether, and the nurse professed to understand that this was so. "Every now and then I asked, 'Do you understand that I am not to be operated on?' 'Yes, I understand; ether examination.' 'But,' I asked, 'I understand that this preparation is for operation.' She said, 'It is just the same in ether examination as in operation -- the same preparation.'" The nurse with whom this conversation is said to have occurred left the ward early in the morning, and the operation was performed in her absence the following afternoon. Was she to infer from the plaintiff's words that a

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[62] Added. It is this rationale that gave basis to the legal doctrine of the *captain of the ship*, the rule that the superior was responsible for all in-scope acts of his underlings.

distinguished surgeon intended to mutilate the plaintiff's body in defiance of the plaintiff's orders? Was it her duty, as a result of this talk, to report to the superintendent of the hospital that the ward was about to be utilized for the commission of an assault [today, a battery]? I think that no such interpretation of the facts would have suggested itself to any reasonable mind. The preparation for an ether examination is to some extent the same as for an operation. The hour was midnight, and the plaintiff was nervous and excited. The nurse soothed her by acquiescing in the statement that an ether examination was all that was then intended. An ether examination *was* intended, and how soon the operation was to follow, if at all, the nurse had no means of knowing. Still less had she reason to suspect that it would follow against the plaintiff's orders. If, when the following afternoon came, the plaintiff persisted in being unwilling to submit to an operation, the presumption was that the distinguished surgeon in charge of the case would perform none. There may be cases where a patient ought not to be advised of a contemplated operation until shortly before the appointed hour. To discuss such a subject at midnight might cause needless and even harmful agitation. About such matters a nurse is not qualified to judge. She is drilled to habits of strict obedience. She is accustomed to rely unquestioningly upon the judgment of her superiors. No woman occupying such a position would reasonably infer from the plaintiff's words that it was the purpose of the surgeons to operate whether the plaintiff forbade it or not. I conclude, therefore, that the plaintiff's statements to the nurse on the night before the operation are insufficient to charge the hospital with notice of a contemplated wrong. I can conceive of cases where a patient's struggles or outcries in the effort to avoid an operation might be such as to give notice to the administrative staff that the surgeons were acting in disregard of their patient's commands. In such circumstances, it may well be that by permitting its facilities to be utilized for such a purpose without resistance or at least protest, the hospital would make itself a party to the trespass, and become liable as a joint tortfeasor. *Sharp v. Erie R. R. Co.,* 184 N. Y. 100 (1906). . . .

Still more clearly, the defendant is not chargeable with notice because of the plaintiff's statements to the physician who administered the gas and ether. She says she asked him whether an operation was to be performed, and that he told her he did not know; that his duty was to give the gas, and nothing more. She answered that she wished to tell some one that there must be no operation; that she had come merely for an ether examination, and he told her that if she had come only for examination, nothing else would be done. There is nothing in the record to suggest that he believed anything to the contrary. He took no part in the operation, and had no knowledge of it. After the gas was administered she was taken into another room. It does not appear, therefore, that this physician was a party to any wrong. In any event, he was not the servant of the hospital. His position in that respect does not differ from that of the operating surgeon. If he was a party to the trespass, he did not subject the defendant to liability.

The conclusion, therefore, follows that the trial judge did not err in his direction of a verdict. A ruling would indeed, be an unfortunate one that might constrain charitable institutions, as a measure of self-protection, to limit their activities. A hospital opens its doors without discrimination to all who seek its aid. It gathers in its

wards a company of skilled physicians and trained nurses, and places their services at the call of the afflicted, without scrutiny of the character or the worth of those who appeal to it, looking at nothing and caring for nothing beyond the fact of their affliction. In this beneficent work, it does not subject itself to liability for damages though the ministers of healing whom it has selected have proved unfaithful to their trust.

The judgment should be affirmed, with costs.

SUPERINTENDENT OF BELCHERTOWN STATE SCHOOL
v.
JOSEPH SAIKEWICZ

Supreme Judicial Court of Massachusetts, 1977
370 N.E.2d 417

Opinion by Liacos, J.

On April 26, 1976, William E. Jones, superintendent of the Belchertown State School (a facility of the Massachusetts Department of Mental Health), and Paul R. Rogers, a staff attorney at the school, petitioned the Probate Court for Hampshire County for the appointment of a guardian of Joseph Saikewicz, a resident of the State School. Simultaneously they filed a motion for the immediate appointment of a guardian *ad litem*, with authority to make the necessary decisions concerning the care and treatment of Saikewicz, who was suffering with acute myeloblastic monocytic leukemia. The petition alleged that Saikewicz was a mentally retarded person in urgent need of medical treatment and that he was a person with disability incapable of giving informed consent for such treatment.

On May 5, 1976, the probate judge appointed a guardian *ad litem.* On May 6, 1976, the guardian *ad litem* filed a report with the court. The guardian *ad litem's* report indicated that Saikewicz's illness was an incurable one, and that although chemotherapy was the medically indicated course of treatment it would cause Saikewicz significant adverse side effects and discomfort. The guardian *ad litem* concluded that these factors, as well as the inability of the ward to understand the treatment to which he would be subjected and the fear and pain he would suffer as a result, outweighed the limited prospect of any benefit from such treatment, namely, the possibility of some uncertain but limited extension of life. He therefore recommended "that not treating Mr. Saikewicz would be in his best interests."

A hearing on the report was held on May 13, 1976. Present were the petitioners and the guardian *ad litem.* The record before us does not indicate whether a guardian for Saikewicz was ever appointed. After hearing the evidence, the judge entered findings of fact and an order that in essence agreed with the recommendation of the guardian *ad litem.* The decision of the judge appears to be based in part on the testimony of Saikewicz's two attending physicians who recommended against chemotherapy. The judge then reported to the appeals court . . . two questions. . . :

> 1) Does the probate court under its general or any special jurisdiction have the authority to order, in circumstances it deems appropriate, the withholding of medical treatment from a person even though such withholding of treatment might contribute to a shortening of the life of such person?

2) On the facts reported in this case, is the Court correct in ordering that no treatment be administered to said Joseph Saikewicz now or at any time for his condition of acute myeloblastic monocetic leukemia except by further order of the Court?

. . . [D]irect appellate review was allowed by this court. . . .

I. [Facts]

The judge below found that Joseph Saikewicz, at the time the matter arose, was 67-years-old, with an I.Q. of ten and a mental age of approximately two years and eight months. He was profoundly mentally retarded. The record discloses that, apart from his leukemic condition, Saikewicz enjoyed generally good health. He was physically strong and well built, nutritionally nourished, and ambulatory. He was not, however, able to communicate verbally -- resorting to gestures and grunts to make his wishes known to others and responding only to gestures or physical contacts. . . . As a result of his condition, Saikewicz had lived in state institutions since 1923 and had resided at the Belchertown State School since 1928. Two of his sisters, the only members of his family who could be located, were notified of his condition and of the hearing, but they preferred not to attend or otherwise become involved.

On April 19, 1976, Saikewicz was diagnosed as suffering from acute myeloblastic monocytic leukemia. . . . The disease tends to cause internal bleeding and weakness, and, in the acute form, severe anemia and high susceptibility to infection. The particular form of the disease present in this case, acute myeloblastic monocytic leukemia is . . . invariably fatal.

Chemotherapy . . . involves the administration of drugs over several weeks, the purpose of which is to kill the leukemia cells. This treatment unfortunately affects normal cells as well. One expert testified that the end result, in effect, is to destroy the living vitality of the bone marrow. Because of this effect, the patient becomes very anemic and may bleed or suffer infections -- a condition which requires a number of blood transfusions. In this sense, the patient immediately becomes much *sicker* with the commencement of chemotherapy, and there is a possibility that infections during the initial period of severe anemia will prove fatal. Moreover, while most patients survive chemotherapy, remission of the leukemia is achieved in only 30 to 50% of the cases. . . . If remission does occur, it typically lasts for between two and thirteen months although longer periods of remission are possible. . . . According to the medical testimony before the court below, persons over age 60 have more difficulty tolerating chemotherapy and the treatment is likely to be less successful than in younger patients. This prognosis may be compared with the doctors' estimates that, left untreated, a patient in Saikewicz's condition would live for a matter of weeks or, perhaps, several months. According to the testimony, a decision to allow the disease to run its natural course would not result in pain for the patient, and death would probably come without discomfort.

An important facet of the chemotherapy process, to which the judge below directed careful attention, is the problem of serious adverse side effects caused by the treating drugs. Among these side effects are severe nausea, bladder irritation, numbness and tingling of the extremities, and loss of hair. The bladder irritation can be avoided, however, if the patient drinks fluids, and the nausea can be treated by drugs. It was the opinion of the guardian *ad litem*, as well as the doctors who testified before the probate judge, that most people elect to suffer the side effects of chemotherapy rather than to allow their leukemia to run its natural course.

> Drawing on the evidence before him . . [t]he judge below found:
>
> That the majority of persons suffering from leukemia who are faced with a choice of receiving or foregoing such chemotherapy, and who are able to make an informed judgment thereon, choose to receive treatment in spite of its toxic side effects and risks of failure.
>
> . . .
>
> That, considering the age and general state of health of said JOSEPH SAIKEWICZ, there is only a 30-40 percent chance that chemotherapy will produce a remission of said leukemia, which remission would probably be for a period of time of from 2 to 13 months, but that said chemotherapy will certainly not completely cure such leukemia.
>
> That if such chemotherapy is to be administered at all, it should be administered immediately, inasmuch as the risks involved will increase and the chances of successfully bringing about remission will decrease as time goes by.
>
> . . .
>
> That said JOSEPH SAIKEWICZ is not now in pain and will probably die within a matter of weeks or months a relatively painless death due to the leukemia unless other factors should intervene to themselves cause death.
>
> . . .

Balancing these various factors, the judge concluded that the following considerations weighed *against* administering chemotherapy to Saikewicz: 1) his age, 2) his inability to cooperate with the treatment, 3) probable adverse side effects of treatment, 4) low chance of producing remission, 5) the certainty that treatment will cause immediate suffering, and 6) the quality of life possible for him even if the treatment does bring about remission.

The following considerations were determined to weigh in *favor* of chemotherapy: "1) the chance that his life may be lengthened thereby, and 2) the fact that most people in his situation when given a chance to do so elect to take the gamble of treatment."

Concluding that, in this case, the negative factors of treatment exceeded the benefits, the probate judge ordered on May 13, 1976, that no treatment be administered to Saikewicz for his condition of acute myeloblastic monocytic leukemia except by further order of the court. The judge further ordered that all reasonable and necessary supportive measures be taken, medical or otherwise, to safeguard the well-being of Saikewicz in all other respects and to reduce as far as possible any suffering or discomfort which he might experience.

. . .

Saikewicz died on September 4, 1976, at the Belchertown State School hospital. Death was due to bronchial pneumonia, a complication of the leukemia. Saikewicz died without pain or discomfort.

II. [Issues]

We recognize at the outset that this case presents novel issues of fundamental importance that should not be resolved by mechanical reliance on legal doctrine. . . . [T]he principal areas of determination are:

> A. The nature of the right of any person, competent or incompetent, to decline potentially life-prolonging treatment.
>
> B. The legal standards that control the course of decision whether or not potentially life-prolonging, but not life-saving, treatment should be administered to a person who is not competent to make the choice.
>
> C. The procedures that must be followed in arriving at that decision.

[T]he questions to be discussed in the first two areas are closely interrelated. We take the view that the substantive rights of the competent and the incompetent person are the same in regard to the right to decline potentially life-prolonging treatment. The factors which distinguish the two types of persons are found only in the area of how the state should approach the preservation and implementation of the rights of an incompetent person and in the procedures necessary to that process of preservation and implementation. We treat the matter in the sequence above stated. . . .

A. [Personal Rights]

1. It has been said that "[t]he law always lags behind the most advanced thinking in every area. It must wait until the theologians and the moral leaders and events have created some common ground, some consensus." Burger, The Law and Medical Advances, 67 *Annals Internal Medicine Supp.* 7, 15, 17 (1967), quoted in Elkinton, "The Dying Patient, the Doctor, and the Law," 13 *Vill. L. Rev.* 740 (1968). We therefore think it advisable to consider the framework of medical ethics which influences a doctor's decision as to how to deal with the terminally ill patient. While these considerations are not controlling, they ought to be considered for the insights they give us.

Advances in medical science have given doctors greater control over the time and nature of death. . . . With the development of the new techniques, serious questions as to what may constitute acting in the best interests of the patient have arisen.

The nature of the choice has become more difficult because physicians have begun to realize that in many cases the effect of using extraordinary measures to prolong life is to "only prolong suffering, isolate the family from their loved one at a time when they may be close at hand or result in economic ruin for the family." Lewis, "Machine Medicine and Its Relation to the Fatally Ill," 206 *J.A.M.A.* 387 (1968).

Recognition of these factors led the Supreme Court of New Jersey to observe "that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable." *In re Quinlan,* 70 N.J. 10, 47 (1976).

. . .

The current state of medical ethics in this area is expressed by one commentator who states that: "we should not use *extraordinary* means[63] of prolonging life or its semblance when, after careful consideration, consultation and the application of the most well conceived therapy it becomes apparent that there is no hope for the recovery of the patient. Recovery should not be defined simply as the ability to remain alive; it should mean life without intolerable suffering." Lewis, *supra.* See Collins, "Limits of

[63] Added. The term *extraordinary* as used here does not mean *unusual* or *uncommon*; it is part of the phrase *extraordinary means* and has a very specific meaning in Roman Catholic moral theology. "*Extraordinary means* is a bioethical term generally encompassing those drugs, devices, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience or which, if used, would offer no reasonable hope of benefit." Conversely, "*ordinary means* is a bioethical term encompassing drugs, devices, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience." [Emphasis added.] *Health Law for Federal Sector Administrators*, Glossary, Karin Waugh Zucker and Martin J. Boyle, eds. (not formally published; printed by the Army Medical Department Center and School, 8th ed., 2000).

Medical Responsibility in Prolonging Life," 206 *J.A.M.A.* 389 (1968); Williamson, "Life or Death -- Whose Decision?" 197 *J.A.M.A.* 793 (1966).

Our decision in this case is consistent with the current medical ethos in this area.

2. There is implicit recognition in the law of the Commonwealth, as elsewhere, that a person has a strong interest in being free from nonconsensual invasion of his bodily integrity. . . . One means by which the law has developed in a manner consistent with the protection of this interest is through the development of the doctrine of informed consent. . . . Of even broader import, but arising from the same regard for human dignity and self-determination, is the unwritten constitutional right of privacy found in the penumbra of specific guaranties of the Bill of Rights. *Griswold v. Connecticut,* 381 U.S. 479 (1965). As this constitutional guarantee reaches out to protect the freedom of a woman to terminate pregnancy under certain conditions, *Roe v. Wade,* 410 U.S. 113 (1973), so it encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances. *In re Quinlan,* 355 A.2d 647 (NJ, 1976). In the case of a person incompetent to assert this constitutional right of privacy, it may be asserted by that person's guardian in conformance with the standards and procedures set forth in Sections II (B) and II (C) of this opinion.

3. The question when the circumstances are appropriate for the exercise of this privacy right depends on the proper identification of state interests. . . .

. . .

. . . As distilled from the cases, the state has claimed interest in 1) the preservation of life; 2) the protection of the interests of innocent third parties; 3) the prevention of suicide; and 4) maintaining the ethical integrity of the medical profession.

It is clear that the most significant of the asserted state interests is that of the preservation of human life. . . The interest of the state in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation. There is a substantial distinction in the state's insistence that human life be saved where the affliction is curable, as opposed to the state interest where, as here, the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended. Even if we assume that the state has an additional interest in seeing to it that individual decisions on the prolongation of life do not in any way tend to *cheapen* the value which is placed in the concept of living, see *Roe v. Wade, supra,* we believe it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness. The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

A second interest of considerable magnitude, which the state may have some interest in asserting, is that of protecting third parties, particularly minor children, from the emotional and financial damage which may occur as a result of the decision of a competent adult to refuse lifesaving or life-prolonging treatment. Thus, in *Holmes v. Silver Cross Hospital*, 340 F. Supp. 125 (1972), the court held that, while the state's interest in preserving an individual's life was not sufficient, by itself, to outweigh the individual's interest in the exercise of free choice, the possible impact on minor children would be a factor which might have a critical effect on the outcome of the balancing process. Similarly, in the Georgetown case the court held that one of the interests requiring protection was that of the minor child in order to avoid the effect of *abandonment* on that child as a result of the parent's decision to refuse the necessary medical measures. *Application of the President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (1964).

The last state interest requiring discussion is that of the maintenance of the ethical integrity of the medical profession as well as allowing hospitals the full opportunity to care for people under their control. The force and impact of this interest is lessened by the prevailing medical ethical standards. Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the state's interest in protecting the same. . . .

. . . Two of the four categories of state interests that we have identified, the protection of third parties and the prevention of suicide, are inapplicable to this case. The third, involving the protection of the ethical integrity of the medical profession was satisfied on two grounds. The probate judge's decision was in accord with the testimony of the attending physicians of the patient. The decision is in accord with the generally accepted views of the medical profession, as set forth in this opinion. The fourth state interest -- the preservation of life -- has been viewed with proper regard for the heavy physical and emotional burdens on the patient if a vigorous regimen of drug therapy were to be imposed to effect a brief and uncertain delay in the natural process of death. To be balanced against these state interests was the individual's interest in the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity and privacy. . . . We therefore turn to consider the unique considerations arising in this case by virtue of the patient's inability to appreciate his predicament and articulate his desires.

B. [Legal Standards]

. . .

. . . [W]e recognize a general right in all persons to refuse medical treatment in appropriate circumstances. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both.

. . .

The best interests of an incompetent person are not necessarily served by imposing on such persons results not mandated as to competent persons similarly situated. It does not advance the interest of the state or the ward to treat the ward as a person of lesser status or dignity than others. To protect the incompetent person within its power, the state must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons. If a competent person faced with death may choose to decline treatment which not only will not cure the person but which substantially may increase suffering in exchange for a possible yet brief prolongation of life, then it cannot be said that it is always in the "best interests" of the ward to require submission to such treatment. Nor do statistical factors indicating that a majority of competent persons similarly situated choose treatment resolve the issue. The significant decisions of life are more complex than statistical determinations. Individual choice is determined not by the vote of the majority but by the complexities of the singular situation viewed from the unique perspective of the person called on to make the decision. To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality.

The trend in the law has been to give incompetent persons the same rights as other individuals. *Boyd v. Registrars of Voters of Belchertown,* 368 Mass. 631 (1975). Recognition of this principle of equality requires understanding that in certain circumstances it may be appropriate for a court to consent to the withholding of treatment from an incompetent individual. This leads us to the question of how the right of an incompetent person to decline treatment might best be exercised so as to give the fullest possible expression to the character and circumstances of that individual.

The problem of decision-making presented in this case is one of first impression before this court, and we know of no decision in other jurisdictions squarely on point. The well publicized decision of the New Jersey Court in *In re Quinlan,* 355 A.2d 647 (NJ, 1976), provides a helpful starting point for analysis, however. . . .

. . .

. . . The doctrine of substituted judgment had its origin over 150 years ago in the area of the administration of the estate of an incompetent person. *Ex parte Whitbread in re Hinde, a Lunatic*, 35 Eng. Rep. 878 (1816). The doctrine was utilized to authorize a gift from the estate of an incompetent person to an individual when the incompetent owed no duty of support. The English court accomplished this purpose by substituting itself as nearly as possible for the incompetent, and acting on the same motives and considerations as would have moved him. . . .

In modern times the doctrine of substituted judgment has been applied as a vehicle of decision in cases more analogous to the situation presented in this case. In a leading decision on this point, *Strunk v. Strunk*, 445 S.W.2d 145 (KY, 1969), the court held that a court of equity had the power to permit removal of a kidney from an incompetent donor for purposes of effectuating a transplant. The court concluded that, due to the nature of their relationship, both parties would benefit from the completion of the procedure, and hence the court could presume that the prospective donor would, if competent, assent to the procedure.

With this historical perspective, we now reiterate the substituted judgment doctrine as we apply it in the instant case. . . . In short, the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person. Having recognized the right of a competent person to make for himself the same decision as the court made in this case, the question is, do the facts on the record support the proposition that Saikewicz himself would have made the decision under the standard set forth. We believe they do.

. . .

The probate judge identified six factors weighing against administration of chemotherapy. Four of these -- Saikewicz's age, the probable side effects of treatment, the low chance of producing remission, and the certainty that treatment will cause immediate suffering -- were clearly established by the medical testimony to be considerations that any individual would weigh carefully. A fifth factor -- Saikewicz's inability to cooperate with the treatment -- introduces those considerations that are unique to this individual and which therefore are essential to the proper exercise of substituted judgment. The judge heard testimony that Saikewicz would have no comprehension of the reasons for the severe disruption of his formerly secure and stable environment occasioned by the chemotherapy. He therefore would experience fear without the understanding from which other patients draw strength. The inability to anticipate and prepare for the severe side effects of the drugs leaves room only for confusion and disorientation. The possibility that such a naturally uncooperative patient would have to be physically restrained to allow the slow intravenous administration of drugs could only compound his pain and fear, as well as possibly jeopardize the ability of his body to withstand the toxic effects of the drugs.

The sixth factor identified by the judge as weighing against chemotherapy was "the quality of life possible for him even if the treatment does bring about remission." To the extent that this formulation equates the value of life with any measure of the quality of life, we firmly reject it. A reading of the entire record clearly reveals, however, the judge's concern that special care be taken to respect the dignity and worth of Saikewicz's life precisely because of his vulnerable position. The judge, as well as all the parties, was keenly aware that the supposed inability of Saikewicz, by virtue of his mental retardation, to appreciate or experience life had no place in the decision before them. Rather than reading the judge's formulation in a manner that demeans the value of the life of one who is mentally retarded, the vague, and perhaps ill-chosen, term *quality of life* should be understood as a reference to the continuing state of pain and disorientation precipitated by the chemotherapy treatment. Viewing the term in this manner, together with the other factors properly considered by the judge, we are satisfied that the decision to withhold treatment from Saikewicz was based on a regard for his actual interests and preferences and that the facts supported this decision.

C. [Procedure]

We turn now to a consideration of the procedures appropriate for reaching a decision where a person allegedly incompetent is in a position in which a decision as to the giving or withholding of life-prolonging treatment must be made. . . . involved serious and painful intrusions on the patient's body. While an emergency existed with regard to taking action to begin treatment, it was not a case in which immediate action was required. Nor was this a case in which life-saving, as distinguished from life-prolonging, procedures were available. Because the individual involved was thought to be incompetent to make the necessary decisions, the officials of the state institutions properly initiated proceedings in the probate court.

. . . The first step is to petition the court for the appointment of a guardian *c.* or a temporary guardian . . . [depending upon the time available –there is a seven-day notice requirement on a hearing for the appointment of a guardian.] . . . [T]he issues before the court are 1) whether the person involved is mentally retarded within the meaning of the statute (G. L. c. 201, §6A) and 2), if the person is mentally retarded, who shall be appointed guardian. As an aid to the judge in reaching these two decisions, it will often be desirable to appoint a guardian *ad litem, sua sponte* or on motion, to represent the interests of the person. Moreover, we think it appropriate, and highly desirable, in cases such as the one before us to charge the guardian *ad litem* with an additional responsibility to be discharged if there is a finding of incompetency. This will be the responsibility of presenting to the judge, after as thorough an investigation as time will permit, all reasonable arguments in favor of administering treatment to prolong the life of the individual involved. This will ensure that all viewpoints and alternatives will be aggressively pursued and examined at the subsequent hearing where it will be determined whether treatment should or should not be allowed. The report of the guardian or temporary guardian will, of course, also be available to the judge at this hearing on the ultimate issue of treatment. Should the probate judge then be satisfied that

the incompetent individual would, as determined by the standards previously set forth, have chosen to forgo potentially life-prolonging treatment, the judge shall issue the appropriate order. . . .

. . . . [T]he probate judge may, at any step in these proceedings, avail himself or herself of the additional advice or knowledge of any person or group. We note here that many healthcare institutions have developed medical ethics committees or panels to consider many of the issues touched on here. Consideration of the findings and advice of such groups as well as the testimony of the attending physicians and other medical experts ordinarily would be of great assistance to a probate judge faced with such a difficult decision. We believe it desirable for a judge to consider such views wherever available and useful to the court. We do not believe, however, that this option should be transformed by us into a required procedure. We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent. Thus, we reject the approach adopted by the New Jersey Supreme Court in the *Quinlan* case of entrusting the decision whether to continue artificial life support to the patient's guardian, family, attending doctors, and hospital ethics committee. . . . [T]he New Jersey Supreme Court concluded that "a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome." *Id.* at 669.

We do not view the judicial resolution of this most difficult and awesome question -- whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision -- as constituting a *gratuitous encroachment* on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.

III. [Conclusion]

[W]e conclude that the probate judge acted appropriately in this case. For these reasons we issued our order of July 9, 1976, and responded as we did to the questions of the probate judge.

TARASOFF v. THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

Supreme Court of California, 1976
551 P.2d 334

Opinion by Tobriner, J.

On October 27, 1969, Prosenjit Poddar killed Tatiana Tarasoff. Plaintiffs, Tatiana's parents, allege that two months earlier Poddar confided his intention to kill Tatiana to Dr. Lawrence Moore, a psychologist employed by the Cowell Memorial Hospital at the University of California at Berkeley. They allege that, on Moore's request, the campus police briefly detained Poddar but released him when he appeared rational. They further claim that Dr. Harvey Powelson, Moore's superior, then directed that no further action be taken to detain Poddar. No one warned plaintiffs of Tatiana's peril.

[Additional statement of facts; reordered.] Poddar was a voluntary outpatient receiving therapy at Cowell Memorial Hospital. Poddar informed Moore, his therapist, that he was going to kill an unnamed girl, readily identifiable as Tatiana, when she returned home from spending the summer in Brazil. Moore, with the concurrence of Dr. Gold, who had initially examined Poddar, and Dr. Yandell, Assistant to the Director of the Department of Psychiatry, decided that Poddar should be committed for observation in a mental hospital. Moore orally notified Officers Atkinson and Teel of the campus police that he would request commitment. He then sent a letter to Chief William Beall requesting the assistance of the [campus] police department in securing Poddar's confinement. Officers Atkinson, Brownrigg, and Halleran took Poddar into custody but, satisfied that Poddar was rational, released him on his promise to stay away from Tatiana. Powelson, Director of the Department of Psychiatry at Cowell Memorial Hospital, then asked the police to return Moore's letter, directed that all copies of the letter and notes that Moore had taken as therapist be destroyed, and "ordered no action to place Prosenjit Poddar in 72-hour treatment and evaluation facility."

Concluding that these facts set forth causes of action against neither therapists and policemen involved, nor against the Regents of the University of California as their employer, the superior court . . . [dismissed] without leave to amend. This appeal ensued.

[The portion of the case which follows deals primarily with the duties and liabilities of the therapists.]

Plaintiffs' complaints predicate liability on two grounds: defendants' failure to warn plaintiffs of the impending danger and their failure to bring about Poddar's confinement pursuant to . . . [California] Welfare. & Inst. Code, §5000 ff. Defendants,

in turn, assert that they owed no duty of reasonable care to Tatiana and that they are immune from suit under the California Tort Claims Act of 1963.

We shall explain that defendant therapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

. . . [P]laintiffs admit that defendant therapists notified the police, but argue on appeal that the therapists failed to exercise reasonable care to protect Tatiana in that they did not confine Poddar and did not warn Tatiana or others likely to apprise her of the danger. . . .

. . .

. . . [Plaintiffs argue] that Tatiana's death proximately resulted from defendants' negligent failure to warn Tatiana or others likely to apprise her of her danger. . . . Defendants, however, contend that in the circumstances of the present case they owed no duty of care to Tatiana or her parents and that, in the absence of such duty, they were free to act in careless disregard of Tatiana's life and safety.

In analyzing this issue, we bear in mind that legal duties are not discoverable facts of nature, but merely conclusory expressions that, in cases of a particular type, liability should be imposed for damage done. As stated in *Dillon v. Legg,* 441 P.2d 912, 916 (CA, 1968): "The assertion that liability must . . . be denied because defendant bears no *duty* to plaintiff 'begs the essential question -- whether the plaintiff's interests are entitled to legal protection against the defendant's conduct. . . . [Duty] is not sacrosanct in itself, but only an expression of the sum total of those considerations of policy which lead the law to say that the particular plaintiff is entitled to protection..'" Prosser, *Law of Torts* [3d ed. 1964] at pp. 332-333.

In the landmark case of *Rowland v. Christian*, 443 P.2d 561, 564 (CA, 1968), Justice Peters recognized that liability should be imposed "for injury occasioned to another by his want of ordinary care or skill". . . . Thus, Justice Peters, quoting from *Heaven v. Pender,* 11 Q.B.D. 503, 509 (1883), stated: "whenever one person is by circumstances placed in such a position with regard to another . . . that if he did not use ordinary care and skill in his own conduct . . . he would cause danger of injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid such danger."

We depart from this *fundamental principle* only upon the balancing of a number of considerations; major ones are the foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for breach, and the availability, cost and prevalence of insurance for the risk involved.

The most important of these considerations in establishing duty is foreseeability. As a general principle, a "defendant owes a duty of care to all persons who are foreseeably endangered by his conduct, with respect to all risks which make the conduct unreasonably dangerous." As we shall explain, however, when the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person or to the potential victim. . . . [T]he relationship between a therapist and his patient satisfies this requirement. . . .

Although, as we have stated above, under the common law, as a general rule, one person owed no duty to control the conduct of another,[64] nor to warn those endangered by such conduct (*Restatement 2nd of Torts*, *supra*, §314, comment c.; Prosser, *Law of Torts*, §56, p. 341, 4th ed., (1971)) the courts have carved out an exception to this rule in cases in which the defendant stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct (see *Restatement 2d Torts*, *supra*, §§315-320). Applying this exception to the present case, we note that a relationship of defendant therapists to either Tatiana or Poddar will suffice to establish a duty of care; as explained in §315 of the *Restatement 2nd of Torts*, a duty of care may arise from either "a) a special relation[ship] between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or b) a special relation[ship] . . . between the actor and the other which gives to the other a right of protection."

Although plaintiffs' pleadings assert no special relation between Tatiana and defendant therapists, they establish as between Poddar and defendant therapists the special relation that arises between a patient and his doctor or psychotherapist. Such a relationship may support affirmative duties for the benefit of third persons. Thus, for example, a hospital must exercise reasonable care to control the behavior of a patient

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[64] The rule derives from the common law's distinction between misfeasance [-- the improper doing of an act which a person might lawfully do --] and nonfeasance [--the omission of an act which a person ought to do], and its reluctance to impose liability for the latter. Morally questionable, the rule owes its survival to "the difficulties of setting any standards of unselfish service to fellow men, and of making any workable rule to cover possible situations. . . [Consequently,] courts have increased the number of instances in which affirmative duties are imposed not by direct rejection of the common law rule, but by expanding the list of special relationships which will justify departure from that rule.

which may endanger other persons.[65] A doctor must also warn a patient if the patient's condition or medication renders certain conduct, such as driving a car, dangerous to others.[66]

. . .

Since it involved a dangerous mental patient, the decision in *Merchants National Bank & Trust Co. of Fargo v. United States,* 272 F.Supp. 409 (1967), comes closer to the issue. The Veterans Administration arranged for the patient to work on a local farm, but did not inform the farmer of the man's background. The farmer consequently permitted the patient to come and go freely during nonworking hours; the patient borrowed a car, drove to his wife's residence and killed her. Notwithstanding the lack of any *special relationship* between the Veterans Administration and the wife, the court found the Veterans Administration liable for the wrongful death of the wife.

In their summary of the relevant rulings Fleming and Maximov conclude that the "case law should dispel any notion that to impose on the therapists a duty to take precautions for the safety of persons threatened by a patient, where due care so requires, is in any way opposed to contemporary ground rules on the duty relationship. On the contrary, there now seems to be sufficient authority to support the conclusion that by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient." (Fleming and Maximov, "The Patient or His Victim: The Therapist's Dilemma" 62 *Cal. L. Rev.* 1025, 1030 (1974)).

Defendants contend, however, that imposition of a duty to exercise reasonable care to protect third persons is unworkable because therapists cannot accurately predict whether or not a patient will resort to violence. In support of this argument *amicus* representing the American Psychiatric Association and other professional societies cites numerous articles which indicate that therapists, in the present state of the art, are unable reliably to predict violent acts; their forecasts, *amicus* claims, tend consistently to over predict violence, and indeed are more often wrong than right. Since predictions of violence are often erroneous, *amicus* concludes, the courts should not render rulings that predicate the liability of therapists upon the validity of such predictions.

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[65] When a "hospital has notice or knowledge of facts from which it might reasonably be concluded that a patient would be likely to harm himself *or others* unless preclusive measures were taken, then the hospital must use reasonable care in the circumstances to prevent such harm." *Vistica v. Presbyterian Hospital,* 432 P.2d 193, 197 (CA, 1967). A mental hospital may be liable if it negligently permits the escape or release of a dangerous patient. *Semler v. Psychiatric Institute of Washington, D.C.,* 538 F.2d 121 (1976); *Underwood v. United States,* 356 F.2d 92 (1966); and *Fair v. United States*, 234 F.2d 288 (1956). A cause of action was upheld against a hospital staff doctor whose negligent failure to admit a mental patient resulted in that patient assaulting the plaintiff. *Greenberg v. Barbour,* 322 F.Supp. 745 (1971).

[66] *Kaiser v. Suburban Transportation System*, 398 P.2d 14 (WA, 1965).

The role of the psychiatrist, who is indeed a practitioner of medicine, and [the role] of the psychologist, who performs an allied function, are like that of the physician who must conform to the standards of the profession and who must often make diagnoses and predictions based upon such evaluations. Thus the judgment of the therapist in diagnosing emotional disorders and in predicting whether a patient presents a serious danger of violence is comparable to the judgment which doctors and professionals must regularly render under accepted rules of responsibility.

We recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. . . . [W]e do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances." (*Bardessono v. Michels,* 478 P.2d 480, 484 (CA, 1970); *Quintal v. Laurel Grove Hospital,* 397 P.2d 161 (CA, 1964). Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence.

In the instant case, however, the pleadings do not raise any question as to failure of defendant therapists to predict that Poddar presented a serious danger of violence. On the contrary, the present complaints allege that defendant therapists did in fact predict that Poddar would kill, but were negligent in failing to warn.

Amicus contends, however, that even when a therapist does in fact predict that a patient poses a serious danger of violence to others, the therapist should be absolved of any responsibility for failing to act to protect the potential victim. In our view, however, once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. While the discharge of this duty of due care will necessarily vary with the facts of each case, in each instance the adequacy of the therapist's conduct must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances. As explained by Fleming and Maximov, *supra*, at 1067:

> . . . the ultimate question of resolving the tension between the conflicting interests of patient and potential victim is one of social policy, not professional expertise. . . . In sum, the therapist owes a legal duty not only to his patient, but also to his patient's would-be victim and is subject in both respects to scrutiny by judge and jury.

. . . Weighing the uncertain and conjectural character of the alleged damage done the patient by such a warning against the peril to the victim's life, we conclude that professional inaccuracy in predicting violence cannot negate the therapist's duty to protect the threatened victim.

The risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved. We would hesitate to hold that the therapist who is aware that his patient expects to attempt to assassinate the President of the United States would not be obligated to warn the authorities because the therapist cannot predict with accuracy that his patient will commit the crime.

Defendants further argue that free and open communication is essential to psychotherapy; that "[u]nless a patient . . . is assured that . . . information [revealed by him] can and will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment . . . depends." (California Senate Committee on the Judiciary, comment on Evidence. Code, §1014). The giving of a warning, defendants contend, constitutes a breach of trust which entails the revelation of confidential communications.

We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault. The legislature has undertaken the difficult task of balancing the countervailing concerns. In Evidence Code §1014, it established a broad rule of privilege to protect confidential communications between patient and psychotherapist. In Evidence Code §1024, the Legislature created a specific and limited exception to the psychotherapist-patient privilege: "There is no privilege . . . if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."

We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger. (See Fleming & Maximov, *supra*, at 1065-1066.)

The revelation of a communication under the above circumstances is not a breach of trust or a violation of professional ethics; as stated in the Principles of Medical Ethics of the American Medical Association (1957), §9: "A physician may not reveal the confidence entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must

yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins.

Our current crowded and computerized society compels the interdependence of its members. In this risk-infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. If the exercise of reasonable care to protect the threatened victim requires the therapist to warn the endangered party or those who can reasonably be expected to notify him, we see no sufficient societal interest that would protect and justify concealment. The containment of such risks lies in the public interest. For the foregoing reasons, we find that plaintiffs' complaints can be amended to state a cause of action against defendants Moore, Powelson, Gold, and Yandell and against the Regents as their employer, for breach of a duty to exercise reasonable care to protect Tatiana.

. . .

Turning now to the police defendants, we conclude that they do not have any . . . special relationship to either Tatiana or to Poddar sufficient to impose upon such defendants a duty to warn respecting Poddar's violent intentions. . . . [67]

. . .

For the reasons stated, we conclude that plaintiffs can amend their complaints to state a cause of action against defendant therapists by asserting that the therapists in fact determined that Poddar presented a serious danger of violence to Tatiana, or pursuant to the standards of their profession should have so determined, but nevertheless failed to exercise reasonable care to protect her from that danger. To the extent, however, that plaintiffs base their claim that defendant therapists breached that duty because they failed to procure Poddar's confinement, the therapists find immunity in Government Code §856. Further, as to the police defendants we conclude that plaintiffs have failed to show that the trial court erred in sustaining their demurrer without leave to amend.

The judgment of the superior court in favor of defendants Atkinson, Beall, Brownrigg, Hallernan, and Teel [all police officers of one variety of another] is affirmed. The judgment of the superior court in favor of defendants Gold, Moore, Powelson, Yandell [all physicians], and the Regents of the University of California is reversed, and the cause remanded for further proceedings consistent with the views expressed herein.

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[67] Confronting, finally, the question whether the defendant police officers are immune from liability for releasing Poddar after his brief confinement, we conclude that they are. The source of their immunity is §5154 of the Welfare and Institutions Code, which declares that: "[the] professional person in charge of the facility providing 72-hour treatment and evaluation, his designee, and the peace officer responsible for the detainment of the person shall not be held civilly or criminally liable for any action by a person released at or before the end of 72 hours . . . ."

UNITED STATES v. KARL BRANDT

Military Tribunal I, (Nürnberg, Germany) 1947

I. Introduction

The *Doctors' Trial* or the *Medical Case* -- officially designated *United States of America v. Karl Brandt, et al (Case No. 1)* -- was tried at the Palace of Justice in Nürnberg before Military Tribunal I. The tribunal convened 139 times (between 25 October 1946 and 20 August 1947).

. . .

The English transcript of the court proceedings runs to 11,538 mimeographed pages. The prosecution introduced into evidence 570 written exhibits [some of which contained several documents], and the defense 901 written exhibits. The Tribunal heard oral testimony of 32 witnesses called by the prosecution and of 30 witnesses, excluding the defendants, called by the defense. Each of the 23 defendants testified in his own behalf, and each was subject to examination on behalf of other defendants. The exhibits offered by both the prosecution and defense contained documents, photographs, affidavits, interrogatories, letters, maps, charts, and other written evidence. The prosecution introduced 49 affidavits; the defense introduced 535 affidavits. The prosecution called 3 defense affiants for cross-examination; the defense called 13 prosecution affiants for cross-examination. The case-in-chief of the prosecution took 25 court days; the case for the defendants took 107 court days. . . .

Selection and arrangement of the *Medical Case* material . . . was accomplished principally by Arnost Horlik-Hochwald, working under the general supervision of Drexel A. Sprecher, Deputy Chief Counsel and Director of Publications, Office U.S. Chief Counsel for War Crimes. . . . [This material comprises all of the first volume of *Trials of War Criminals before the Nürnberg Military Tribunals* and 352 pages of the second volume. This multi-volume work was published by the U.S. Government Printing Office, Washington, D.C. and is dated October 1946 - April 1949. Additional excerpts follow.]

II. Indictment

The United States of America, by the undersigned Telford Taylor, Chief of Counsel for War Crimes, duly appointed to represent said government in the prosecution of war criminals, charges that the defendants herein participated in a common design or conspiracy to commit and did commit war crimes and crimes against humanity, as defined in Control Council Law No. 10, duly enacted by the Allied Control Council on 20 December 1945. These crimes included murders, brutalities, cruelties, tortures, atrocities, and other inhumane acts, as set forth in

counts one, two, and three of this indictment. Certain defendants are further charged with membership in a criminal organization, as set forth in count four of this indictment.

The persons accused as guilty of these crimes and accordingly named as defendants in this case are --

Karl Brandt -- Personal physician to Adolf Hitler; Gruppenfuehrer in the SS and Major General in the Waffen SS; Reich Commissioner for Health and Sanitation; and member of the Reich Research Council.

Siegfried Handloser -- Lieutenant General, Medical Service; Medical Inspector of the Army; and Chief of the Medical Services of the Armed Forces.

Paul Rostock -- Chief Surgeon of the Surgical Clinic in Berlin; Surgical Adviser to the Army; and Chief of the Office for Medical Science and Research under the defendant Karl Brandt, Reich Commissioner for Health and Sanitation.

Oskar Schroeder -- Lieutenant General, Medical Service; Chief of Staff of the Inspectorate of the Medical Service of the Luftwaffe; and Chief of the Medical Service of the Luftwaffe.

Karl Genzken -- Gruppenfueher in the SS and Major General in the Waffen SS; and Chief of the Medical Department of the Waffen SS.

Karl Gebhardt -- Gruppenfuehrer in the SS and Major General in the Waffen SS; personal physician to Reichsfuehrer SS Himmler; Chief Surgeon of the Staff of the Reich Physician SS and Police; and President of the German Red Cross.

Kurt Blome -- Deputy of the Reich Health Leader; and Plenipotentiary for Cancer Research in the Reich Research Council.

Rudolf Brandt -- Colonel in the Allgemeine SS; Personal Administrative Officer to Reichsfuehrer SS Himmler; and Ministerial Counsellor and Chief of the Ministerial Office in the Reich Ministry of the Interior.

Joachim Mrugowsky -- Senior Colonel in the Waffen SS; Chief Hygienist of the Reich Physician SS and Police; and Chief of the Hygenic Institute of the Waffen SS.

Helmut Poppendick -- Senior Colonel in the SS; and Chief of the Personal Staff of the Reich Physician SS and Police.

Wolfram Sievers -- Colonel in the SS; Reich Manager of the Ahnenerbe Society[68] and Director of its Institute for Military Scientific Research; and Deputy Chairman of the Managing Board of Directors of the Reich Research Council.

Gerhard Rose -- Brigadier General, Medical Service of the Air Force; Vice President, Chief of the Department for Tropical Medicine, and Professor of the Robert Koch Institute; and Hygienic Adviser for Tropical Medicine to the Chief of the Medical Service of the Luftwaffe.

Siegfried Ruff -- Director of the Department for Aviation Medicine at the German Experimental Institute for Aviation.

Hans Wolfgang Romberg -- Doctor on the Staff of the Department for Aviation Medicine at the German Experimental Institute for Aviation.

Viktor Brack -- Senior Colonel in the SS and Major in the Waffen SS; and Chief Administrative Officer in the Chancellery of the Fuehrer of the NSDAP.

Herman Becker-Freyseng -- Captain, Medical Service of the Air Force; and Chief of the Department for Aviation Medicine of the Chief of the Medical Service of the Luftwaffe.

Georg August Weltz -- Lieutenant Colonel, Medical Service of the Air Force; and Chief of the Institute for Aviation Medicine in Munich.

Konrad Schaefer -- Doctor on the Staff of the Institute for Aviation Medicine in Berlin.

Waldemar Hoven -- Captain in the Waffen SS; and Chief Doctor of the Buchenwald Concentration Camp.

Wilhelm Beiglboeck -- Consulting Physician to the Luftwaffe.

Adolf Pokorny -- Physician, Specialist in Skin and Venereal Diseases.

Herta Oberheuser -- Physician at the Ravensbrueck Concentration Camp; and Assistant Physician to the defendant Gebhardt at the hospital at Hohnlychen.

Fritz Fischer -- Major in the Waffen SS; and Assistant Physician to the defendant Gebhardt at the Hospital at Hohenlychen.

A. Count One - The Common Design or Conspiracy

[68] This organization, under the direction of Himmler, was supposedly a research society but was actually engaged in pseudo-scientific, historical and ethnographic pursuits to establish the roots and superiority of Aryan society. See John Cornwell's book, *Hitler's Scientists*, 2003.

1. Between September 1939 and April 1945 all of the defendants herein, acting pursuant to a common design, unlawfully, willfully, and knowingly did conspire and agree together and with each other and with divers other persons, to commit war crimes and crimes against humanity, as defined in Control Council Law No. 10, Article II.[69]

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[69] Control Council Law No. 10

. . .

Article II

1. Each of the following acts is recognized as a crime:

a) *Crimes against Peace.* Initiation of invasions of other countries and wars of aggression in violation of international law and treaties, including but not limited to planning, preparation, initiation or waging a war of aggression, or a war of violation of international treaties, agreements or assurances, or participation in a common plan or conspiracy for the accomplishment of any of the foregoing.

b) *War Crimes.* Atrocities or offenses against persons or property constituting violations of the laws or customs of war, including but limited to, murder, ill treatment or deportation to slave labor or for any other purpose, of civilian population from occupied territory, murder, or ill treatment of prisoners of war or persons on the seas, killing of hostages, plunder of public or private property, wanton destruction of cities, towns or villages, or devastation not justified by military necessity.

c) *Crimes against Humanity.* Atrocities and offenses, including but not limited to murder, extermination, enslavement, deportation, imprisonment, torture, rape, or other inhumane acts committed against any civilian population, or persecutions on political, racial or religious grounds whether or not in violation of the domestic laws of the country where perpetrated.

d) Membership in categories of a criminal group or organization declared criminal by the International Military Tribunal.

. . .

3. Any person found guilty of any of the crimes above mentioned may upon conviction be punished as shall be determined by the tribunal to be just. Such punishment may consist of one or more of the following:

a) Death.

b) Imprisonment for life or a term of years, with or without hard labor.

c) Fine, and imprisonment with or without hard labor, in lieu thereof.

d) Forfeiture of property.

e) Restitution of property wrongfully acquired.

f) Deprivation of some or all civil rights.

. . .

4. a) The official position of any person, whether as Head of State or as a responsible official in a Government Department, does not free him from responsibility for a crime or entitle him to mitigation of punishment.

b) The fact that any person acted pursuant to the order of his Government or of a superior does not free him from responsibility for a crime, but may be considered in mitigation.

2. Throughout the period covered by this indictment all of the defendants herein, acting in concert with each other and with others, unlawfully, willfully, and knowingly were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the commission of war crimes and crimes against humanity.

3. All of the defendants herein, acting in concert with others for whose acts the defendants are responsible, unlawfully, willfully, and knowingly participated as leaders, organizers, investigators, and accomplices in the formulation and execution of the said common design, conspiracy, plans, and enterprises to commit, and which involved the commission of, war crimes and crimes against humanity.

4. It was part of said common design, conspiracy, plans, and enterprises to perform medical experiments upon concentration camp inmates and other living human subjects, without their consent, in the course of which experiments the defendants committed the murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts more fully described in counts two and three of this indictment.

5. The said common design, conspiracy, plans, and enterprises embraced the commission of war crimes and crimes against humanity as set forth in counts two and three of this indictment, in that the defendants unlawfully, willfully, and knowingly encourages, aided, abetted, and participated in the subjection of thousands of persons, including civilians, and members of the armed forces of nations then at war with the German Reich, to murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts.

B. Count Two - War Crimes

1. Between September 1939 and April 1945, all of the defendants herein unlawfully, willfully, and knowingly committed war crimes, as defined by Article II of Control Council Law No. 10,[70] in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving medical experiments without the subjects' consent, upon civilians and members of the armed forces of nations then at war with the German Reich and who were in the custody of the German Reich in exercise of belligerent control, in the course of which experiments the defendants committed murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts. Such experiments included, but were not limited to, the following:

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5. In any trial or prosecution for a crime herein referred to, the accused shall not be entitled to the benefits of any statute of limitation in respect of the period from 30 January 1933 to 1 July 1945, nor shall any immunity, pardon, or amnesty granted under the Nazi regime be admitted as a bar to trial or punishment.

[70] *Id.*

a) High-Altitude Experiments. From about March 1942 to about August 1942, experiments were conducted at the Dachau concentration camp, for the benefit of the German Air Force, to investigate the limits of human endurance and existence at extremely high altitudes. The experiments were carried out in a low-pressure chamber in which the atmospheric conditions and pressures prevailing at high altitude (up to 68,000 feet) could be duplicated. The experimental subjects were placed in the low-pressure chamber and thereafter the simulated altitude therein was raised. Many victims died as a result of these experiments and others suffered grave injury, torture, and ill-treatment. The defendants Karl Brandt, Handloser, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Ruff, Romberg, Becker-Freyseng, and Weltz are charged with special responsibility for and participation in these crimes.

b) Freezing Experiments. From about August 1942 to about May 1943, experiments were conducted at the Dachau concentration camp, primarily for the benefit of the German Air Force, to investigate the most effective means of treating persons who had been severely chilled or frozen. In one series of experiments the subjects were forced to remain in a tank of ice water for periods up to 3 hours. Extreme rigor developed in a short time. Numerous victims died in the course of these experiments, the subjects were kept naked outdoors for many hours at temperatures below freezing. The victims screamed with pain as parts of their bodies froze. The defendants Karl Brandt, Handloser, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Becker-Freyseng, and Weltz are charged with special responsibility for and participation in these crimes.

c) Malaria Experiments. From about February 1942 to about April 1943, experiments were conducted at the Dachau concentration camp in order to investigate immunization for and treatment of malaria. Healthy concentration camp inmates were infected by mosquitoes or by injections of extracts of the mucous glands of mosquitoes. After having contracted malaria the subjects were treated with various drugs to test their relative efficacy. Over 1,000 involuntary subjects were used in these experiments. Many of the victims died and other suffered severe pain and permanent disability. The defendants Karl Brandt, Handloser, Rostock, Gebhardt, Blome, Rudolf Brandt, Mrugowsky, Poppendick, and Sievers are charged with special responsibility for and participation in these crimes.

d) Lost (Mustard) Gas Experiments. At various times between September 1939 and April 1945, experiments were conducted at Sachsenhausen, Natzweiler, and other concentration camps for the benefit of the German armed forces to investigate the most effective treatment of wounds caused by Lost gas. Lost is a poison gas which is commonly known as mustard gas. Wounds deliberately inflicted on the subjects were infected with Lost. Some of the subjects died as a result of the experiments and other suffered intense pain and injury. The defendants Karl Brandt, Handloser, Blome, Rostock, Gebhardt, Rudolf Brandt and Sievers are charged with special responsibility for and participation in these crimes.

e) Sulfanilamide Experiments. From about July 1942 to about September 1943, experiments to investigate the effectiveness of sulfanilamide were conducted at the Ravensbrueck concentration camp for the benefit of the German armed forces. Wounds deliberately inflicted on the experimental subjects were infected with bacteria such as streptococcus, gas gangrene, and tetanus. Circulation of blood was interrupted by tying off blood vessels at both ends of the wound to create a condition similar to that of a battlefield wound. Infection was aggravated by forcing wood shavings and ground glass into the wounds. The infection was treated with sulfanilamide and other drugs to determine their effectiveness. Some subjects died as a result of these experiments and other suffered serious injury and intense agony. The defendants Karl Brandt, Handloser, Rostock, Schroeder, Becker-Freyseng, Oberheuser, and Fischer are charged with special responsibility for and participation in these crimes.

f) Bone, Muscle, and Nerve Regeneration and Bone Transplantation Experiments. From about September 1942 to about December 1943, experiments were conducted at the Ravensbrueck concentration camp, for the benefit of the German armed forces, to study bone, muscle, and nerve regeneration, and bone transplantation from one person to another. Sections of bones, muscles, and nerves were removed from the subjects. As a result of these operations, many victims suffered intense agony, mutilation, and permanent disability. The defendants Karl Brandt, Handloser, Rostock, Gebhardt, Rudolf Brandt, Oberheuser, and Fischer are charged with special responsibility for and participation in these crimes.

g) Sea-Water Experiments. From about July 1944 to about September 1944, experiments were conducted at the Dachau concentration camp, for the benefit of the German Air Force and Navy, to study various methods of making sea water drinkable. The subjects were deprived of all food and given only chemically processed sea water. Such experiments caused great pain and suffering and resulted in serious bodily injury to the victims. The defendants Karl Brandt, Handloser, Rostock, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Becker-Freyseng, Schaefer, and Beiglboeck are charged with special responsibility for and participation in these crimes.

h) Epidemic Jaundice Experiments. From about June 1943 to about January 1945, experiments were conducted at the Sachsenhausen and Natzweiler concentration camps, for the benefit of the German armed forces, to investigate the causes of, and inoculations against, epidemic jaundice. Experimental subjects were deliberately infected with epidemic jaundice, some of whom died as a result, and others were caused great pain and suffering. The defendants Karl Brandt, Handloser, Rostock, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Rose, and Becker-Freyseng are charged with special responsibility for and participation in these crimes.

i) Sterilization Experiments. From about March 1941 to about January 1945, sterilization experiments were conducted at the Auschwitz and Ravensbrueck concentration camps, and other places. The purpose of these experiments was to develop a method of sterilization which would be suitable for sterilizing millions of people with a minimum of time and effort. These experiments were conducted by means of x-ray, surgery, and various drugs. Thousands of victims were sterilized and thereby suffered great mental and physical anguish. The defendants Karl Brandt, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Brack, Pokorny, and Oberheuser are charged with special responsibility for and participation in these crimes.

j) Typhus Experiments. From about December 1941 to about February 1945, experiments were conducted at the Buchenwald and Natzweiler concentration-camps, for the benefit of the German armed forces, to investigate the effectiveness of typhus and other vaccines. At Buchenwald numerous healthy inmates were deliberately infected with typhus in order to keep the virus alive; over 90 percent of the victims died as a result. Other healthy inmates were used to determine the effectiveness of different typhus vaccines and of various chemical substances. In the course of these experiments 75 percent of the selected number of inmates were vaccinated with one of the vaccines or nourished with one of the chemical substances and, after a period of 3 to 4 weeks, were infected with typhus germs. The remaining 25 percent were infected without any previous protection in order to compare the effectiveness of the vaccines and the chemical substances. As a result hundreds of the persons experimented upon died. Experiments with yellow fever, smallpox, typhoid, paratyphoid A and B, cholera, and diphtheria were also conducted. Similar experiments with the like results were conducted at Natzweiler concentration camp. The defendants Karl Brandt, Handloser, Rostock, Schroeder, Genzken, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Rose, Becker-Freyseng, and Hoven are charged with special responsibility for and participation in these crimes.

k) Experiments with Poison. In or about December 1943 and in or about October 1944, experiments were conducted at the Buchenwald concentration camp to investigate the effect of various poisons upon human beings. The poisons were secretly administered to experimental subjects in their food. The victims died as a result of the poison or were killed immediately in order to permit autopsies. In or about September 1944, experimental subjects were shot with poison bullets and suffered torture and death.

l) Incendiary Bomb Experiments. From about November 1943 to about January 1944, experiments were conducted at the Buchenwald concentration camp to test the effect of various pharmaceutical preparations on phosphorous burns. These burns were inflicted on experimental subjects with phosphorous matter taken from incendiary bombs, and caused severe pain, suffering, and serious bodily injury. The defendants Genzken, Gebhardt, Mrugowsky, and Poppendick are charged with special responsibility for and participation in these crimes.

2. Between June 1943 and September 1944, the defendants Rudolf Brandt and Sievers unlawfully, willfully, and knowingly committed war crimes, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the murder of civilians and members of the armed forces of nations then at war with the German Reich. . . . One hundred twelve Jews were selected for the purpose of completing a skeleton collection for the Reich University of Strasbourg. Their photographs and anthropological measurements were taken. Then, they were killed. Thereafter, comparison tests, anatomical research, studies regarding race, pathological features of the body, form and size of the brain, and other tests were made. The bodies were then sent to Strasbourg and defleshed.

3. Between May 1942 and January 1944, the defendants Blome and Rudolf Brandt unlawfully, willfully, and knowingly committed war crimes . . . in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the murder and mistreatment of tens of thousands of Polish nationals who were civilians and members of the armed forces of a nation then at war with the German Reich and who were in the custody of the German Reich in exercise of belligerent control. These people were alleged to be infected with incurable tuberculosis. On the ground of insuring the health and welfare of Germans in Poland, many tubercular Poles were ruthlessly exterminated while others were isolated in death camps with inadequate medical facilities.

4. Between September 1939 and April 1945, the defendants Karl Brandt, Blome, Brack, and Hoven unlawfully, willfully, and knowingly committed war crimes . . . in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the execution of the so-called *euthanasia* program of the German Reich in the course of which the defendants herein murdered hundreds of thousands of human beings, including nationals of German-occupied countries. This program involved the systematic and secret execution of the aged, insane, incurably ill, of deformed children, and other persons by gas, lethal injections, and diverse other means in nursing homes, hospitals, and asylums. Such persons were regarded as *useless eaters* and a burden to the German war machine. The relatives of these victims were informed that they died from natural causes, such as heart failure. German doctors involved in the *euthanasia* program were also sent to Eastern occupied countries to assist in the mass extermination of Jews.

5. The said war crimes constitute violations of international conventions, . . . the laws and customs of war, the general principles of criminal law as derived from the criminal laws of all civilized nation, the internal penal law of the countries in which such crimes were committed, and of Article II of Control Council Law No. 10.

C. Count Three - Crimes Against Humanity

1. Between September 1939 and April 1945, all of the defendants herein unlawfully, willfully, and knowingly committed crimes against humanity, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving medical experiments, without the subjects' consent, upon German civilians and nationals of other countries, in the course of which experiments the defendants committed murders, brutalities, cruelties, tortures, atrocities, and other inhuman acts. The particulars concerning such experiments are set forth in paragraph 6 of count two of this indictment and are incorporated herein by reference.

2. Between June 1943 and September 1944, the defendants Rudolf Brandt and Sievers unlawfully, willfully, and knowingly committed crimes against humanity . . . in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the murder of German civilians and nationals of other countries. The particulars concerning such murders are set forth in paragraph 7 of count two of this indictment and are incorporated herein by reference.

3. Between May 1942 and January 1944, the defendants Blome and Rudolf Brandt unlawfully, willfully, and knowingly committed crimes against humanity . . . in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the murder and mistreatment of tens of thousands of Polish nationals. The particulars concerning such murder and inhuman treatment are set forth in paragraph 8 of count two of this indictment and are incorporated herein by reference.

4. Between September 1939 and April 1945, the defendants Karl Brandt, Blome, Brack, and Hoven unlawfully, willfully, and knowingly committed crimes against humanity . . . in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the execution of the so-called *euthanasia* program of the German Reich, in the course of which the defendants herein murdered hundreds of thousands of human beings, including German civilians, as well as civilians of other nations. The particulars concerning such murder and inhuman treatment are set forth in paragraph 9 of count two of this indictment and are incorporated herein by reference.

5. The said crimes against humanity constitute violations of international convention, including Article 36 of the Hague Regulations, 1907, the laws and customs of war, the general principles of criminal law as derived from the criminal law of all civilized nations, the internal penal laws of the countries in which such crimes were committed, and of Article II of Control Council Law No. 10.

D. Count Four - Membership in Criminal Organization

1. The defendants Karl Brandt, Genzken, Gebhardt, Rudolf Brandt, Mrugowsky, Peppendick, Sievers, Brack, Hoven, and Fischer are guilty of membership in an organization declared to be criminal by the International Military Tribunal in Case No. 1, in that each of the said defendants was a member of the Schutzstaffe der National-sozialistischen Deutschen Arbeiter Partei (commonly known as the *SS*) after 1 September 1939. Such membership is in violation of paragraph I(d), Article II of Control Council Law No. 10.

Wherefore, this indictment is filed with the Secretary General of the Military Tribunals and the charges herein made against the above named defendants are hereby presented to Military Tribunal No. 1.

III. Opening Statement of the Prosecution by Brigadier General Telford Taylor 9 December 1946

The defendants in this case are charged with murders, tortures, and other atrocities committed in the name of medical science. The victims of these crimes are numbered in the hundreds of thousands. A handful only are still alive; a few of the survivors will appear in this courtroom. But most of these miserable victims were slaughtered outright or died in the course of the tortures to which they were subjected.

For the most part they are nameless dead. To their murderers, these wretched people were not individuals at all. They came in wholesale lots and were treated worse than animals. They were 200 Jews in good physical condition, 50 gypsies, 500 tubercular Poles, or 1,000 Russians. The victims of these crimes are numbered among the anonymous millions who met death at the hands of the Nazis and whose fate is a hideous blot on the page of modern history.

The charges against these defendants are brought in the name of the United States of America. They are being tried by a court of American judges. The responsibilities thus imposed upon the representatives of the United States, prosecutors and judges alike, are grave and unusual. It is owed, not only to the victims and to the parents and children of the victims, that just punishment be imposed on the guilty, but also to the defendants that they be accorded a fair hearing and decision. Such responsibilities are the ordinary burden of any tribunal. Far wider are the duties which we must fulfill here.

These larger obligations run to the peoples and races on whom the scourge of these crimes was laid. There, mere punishment of the defendants, or even of thousands of other equally guilty, can never redress the terrible injuries which the Nazis visited on these unfortunate peoples. For them it is far more important that

these incredible events be established by clear and public proof, so that no one can ever doubt that they were fact and not fable; and that this court, as the agent of the United States and as the voice of humanity, stamp these acts, and the ideas which engendered them, as barbarous and criminal.

We have still other responsibilities here. The defendants in the dock are charged with murder, but this is no mere murder trial. We cannot rest content when we have shown that crimes were committed and that certain persons committed them. To kill, to maim, and to torture is criminal under all modern systems of law. These defendants did not kill in hot blood, nor for personal enrichment. Some of them may be sadists who killed and tortured for sport, but they are not all perverts. They are not ignorant men. Most of them are trained physicians and some of them are distinguished scientists. Yet these defendants, all of whom were fully able to comprehend the nature of their act, and most of whom were exceptionally qualified to form a moral and professional judgment in this respect, are responsible for wholesale murder and unspeakably cruel tortures.

It is our deep obligation to all peoples of the world to show why and how these things happened. It is incumbent upon us to set forth with conspicuous clarity the ideas and motives which moved these defendants to treat their fellow men as less than beasts. The perverse thoughts and distorted concepts which brought about these savageries are not dead. They cannot be killed by force of arms. They must not become a spreading cancer in the breast of humanity. They must be cut out and exposed. . . .

To the German people we owe a special responsibility. . . . To what cause will [their] children ascribe the defeat of the German nation and the devastation that surrounds them? Will they attribute it to the overwhelming weight of numbers and resources? Will they perhaps blame their plight on strategic and military blunders? . . .

If the Germans embrace those reasons as the true cause of their disaster, it will be a sad and fatal thing for Germany and for the world. . . . Such views will lead the Germans straight into the arms of the Prussian militarists to whom defeat is only a glorious opportunity to start a new war game. . . .

The insane and malignant doctrines that Nürnberg spewed forth account alike for the crimes of these defendants and for the terrible fate of Germany under the Third Reich. . . . I do not think the German people have as yet any conception of how deeply the criminal folly that was nazism bit into every phase of German life, or of how utterly ravaging the consequences were. It will be our task to make these things clear.

. . .

A. State Medical Services of the Third Reich [text omitted]

[All but three of the defendants in this trial were doctors. It is worth noting that Karl Brandt was Hitler's personal physician and Plenipotentiary for Health and Medical Services, coordinating the requirements of the military and civilian agencies in the fields of medicine and public health; Handloser was Chief of the Medical Services of the Wehrmacht and had supervisory and professional authority over the medical services of all three branches of the Wehrmacht and the Waffen SS; eight other defendants were members of the medical service of the German Air Force; and seven were members of the medical service of the SS. Of the three who were not physicians, Rudolf Brandt and Brack were administrative officers and Sievers, an SS colonel, was president of the Ahnenerge Society. --Taylor here proceeded to sketch the structure of medical services in the Third Reich, showing how these services fitted into the over-all military organization.]

B. Crimes Committed in the Guise of Scientific Research

. . . [L]et us look at . . . [these experiments] as a whole. Are they a heterogeneous list of horrors, or is there a common denominator for the whole group?

A sort of rough pattern is apparent on the face of the indictment. Experiments concerning high altitude, the effect of cold, and the potability of processed sea water have an obvious relation to aeronautical and naval combat and rescue problems. The mustard gas and phosphorous burn experiments, as well as those relating to the healing value of sulfanilamide for wounds, can be related to air-raid and battlefield medical problems. It is well known that malaria, epidemic jaundice, and typhus were among the principal diseases which had to be combated by the German Armed Forces and by German authorities in occupied territories.

To some degree, the therapeutic pattern outlined above is undoubtedly a valid one, and explains why the Wehrmacht, and especially the German Air Force, participated in these experiments. Fanatically bent upon conquest, utterly ruthless as to the means or instruments to be used in achieving victory, and callous to the sufferings of people whom they regarded as inferior, the German militarists were willing to gather whatever scientific fruit these experiments might yield.

But our proof will show that a quite different and even more sinister objective runs like a red thread through these hideous researches. We will show that in some instances the true object of these experiments was not how to rescue or to cure, but how to destroy and kill. The sterilization experiments were, it is clear, purely destructive in purpose.

[An in depth review of the experiments followed, but is omitted from this extract.]

IV. Evidence

[The extensive summary of evidence, documentary and testimonial is omitted; except that the statement of defendant Karl Brandt is given as illustrative of statements made by all defendants.]

A. Statement of Karl Brandt

There is a word which seems so simple --*order*; and how colossal are its implications. How immeasurable are the conflicts which hide behind the word obey. Both affected me, obey and order, and both imply responsibility. I am a doctor and on my conscience lies the responsibility of being responsible for men and for life. Quite dispassionately the prosecution has brought the charge of crime and murder and they have raised the question of my guilt. It would have no weight if friends and patients were to shield me and speak well of me, saying I had helped and I had healed. There would be many examples of my actions during danger and my readiness to help. All that is now useless. As far as I am concerned I shall not evade these charges. But, the attempt to vindicate myself as a man is my duty towards all who believe in me personally, who trusted in me and who relied upon me as a man as well as a doctor and a superior.

No matter how I was faced with the problem, I have never regarded human experiments as a matter of course, not even when no danger was entailed. But I affirm the necessity for them on grounds of reason. I know that opposition will arise. I know things that disturb the conscience of a medical man, and I know the inner distress that afflicts one when ethics of every form are decided by an order or obedience.

It is immaterial for the experiment whether it is done with or against the will of the person concerned. For the individual the event seems senseless, just as senseless as my actions as a doctor seem when isolated. The sense lies much deeper than that. Can I, as an individual, detach myself from the community? Can I remain outside and do without it? Could I, as a part of this community, evade it by saying I want to live in this community, but I don't want to make any sacrifices for it, either of body or soul? I want to keep a clear conscience. Let them see how they can get along. And yet we, that community and I, are somehow identical.

Thus, I must suffer these contradictions and bear the consequences, even if they remain incomprehensible. I must bear them as my lot in life, which allocates to me its tasks. The meaning is the motive -- devotion to the community. If on its account I am guilty, then on its account I will be answerable.

There was war. In war efforts are all alike. Its sacrifices affect us all. They were incumbent upon me. But are those sacrifices my crime? Did I tread on the precepts of humanity and despise them? Did I pass over human beings and their lives

as if they were nothing? Men will point at me and cry *euthanasia*, and falsely, *the useless, the incapable, the worthless*. But what actually happened? Did not Pastor Bodelschwingh, in the middle of his work at Bethel last year, say that I was an idealist and not a criminal. How could he say that?

Here I am, subject of the most frightful charges, as if I had not only been a doctor, but also a man without heart or conscience. Do you think that it was a pleasure to me to receive the order to permit euthanasia? For 15 years I had toiled at the sickbed and every patient was to me like a brother. I worried about every sick child as if it had been my own. My personal lot was a heavy one. Is that guilt?

Was it not my first thought to limit the scope of euthanasia? Did I not, the moment I was included, try to find a limit and demand a most searching report on the incurables? Were not the appointed professors of the universities there? Who could there be who was better qualified? But I do not want to speak of these questions and of their execution. I am defending myself against the charge of inhuman conduct and base intentions. In the fact of these charges I fight for my right to humane treatment! I know how complicated this problem is. With the utmost fervor I have tortured myself again and again, but no philosophy or other wisdom helped me here. There was the decree and on it there was my name. It is no good saying that I could have feigned sickness. I do not live this life of mine in order to evade fate if I meet it. And, thus I assented to euthanasia. I fully realize the problem; it is as old as mankind, but it is not a crime against man nor against humanity. It is pity for the incurable, literally. Here, I cannot believe like a clergyman or think as a jurist. I am a doctor and I see the law of nature as being the law of reason. In my heart there is love of mankind, and so it is in my conscience. That is why I am a doctor!

When I talked at the time to Pastor Bodelschwingh, the only serious admonisher I knew personally, it seemed at first as if our thoughts were far apart; but the longer we talked and the more we came into the open, the closer and the greater became our mutual understanding. At that time we were not concerned with words. It was a struggle and a search far beyond the human sphere. When the old Pastor Bodelschwingh left me after many hours and we shook hands, his last words were: "That was the hardest struggle of my life." For him as well as for me that struggle remained; and the problem remained too.

If I were to say today that I wish this problem had never come upon me with its convulsive drama, that would be nothing but superficiality in order to make me feel more comfortable in myself. But I am living in these times and I see that they are full of antitheses. Somewhere we all must make a stand. I am fully conscious that when I said "Yes" to euthanasia I did so with the deepest conviction, just as it is my conviction today, that it was right. Death can mean deliverance. Death is life--just as much as birth. It was never meant to be murder. I bear a burden, but it is not the burden of crime. I bear this burden of mine, though with a heavy heart, as my responsibility. I stand before it, and before my conscience, as a man and as a doctor.

V. Summation

Military Tribunal I was established on 25 October 1946 under General Orders No. 68 issued by command of the United States Military Government for Germany. . . .

On 25 October 1946, the Chief of Counsel for War Crimes lodged an indictment against the defendants. . . . Military Tribunal I arraigned the defendants on 21 November 1946, each defendant entering a pleas of *not guilty* to all the charges preferred against him.

The presentation of evidence to sustain the charges contained in the indictment was begun by the prosecution on 9 December 1946. At the conclusion of the prosecution's case in chief the defendants began the presentation of their evidence. All evidence in the case was concluded on 3 July 1947. During the week beginning 14 July 1947, the Tribunal heard arguments by counsel for the prosecution and defense. The personal statements of the defendants were heard on 19 July 1947 on which date the case was finally concluded.

The trial was conducted in two languages -- English and German. It consumed 139 trial days, including six days allocated for final arguments and the personal statements of the defendants. During the 132 trial days used for the presentation of evidence 32 witnesses gave oral evidence for the prosecution and 53 witnesses, including the 23 defendants, gave oral evidence for the defense. In addition, the prosecution put in evidence as exhibits a total of 570 affidavits, reports, and documents; the defense put in a total of 901 -- making a grand total of 1,471 documents received in evidence.

Copies of all exhibits tendered by the prosecution in their case-in-chief were furnished in the German language to the defendants prior to the time of the reception of the exhibits in evidence.

Each defendant was represented at the arraignment and trial by counsel of his selection.

Whenever possible, all applications by defense counsel for the procuring of the personal attendance of persons who made affidavits in behalf of the prosecution were granted and the persons brought to Nürnberg for interrogation or cross-examination by defense counsel. Throughout the trial great latitude in presenting evidence was allowed defense counsel, even to the point at times of receiving in evidence certain matters of but scant probative value.

All of these steps were taken by the Tribunal in order to allow each defendant to present his defense completely, in accordance with the spirit and intent of Military Government Ordinance No. 7, which provides that a defendant shall have the right to

be represented by counsel, to cross-examine prosecution witnesses, and to offer in the case all evidence deemed to have probative value.

The evidence has now been submitted, final arguments of counsel have been concluded, and the Tribunal has heard personal statements from each of the defendants. All that remains to be accomplished in the case is the rendition of judgment and the imposition of sentence.

. . .

A. The Proof as to War Crimes and Crimes Against Humanity

Judged by any standard of proof the record clearly shows the commission of war crimes and crimes against humanity, substantially as alleged in counts two and three of the indictment. Beginning with the outbreak of World War II criminal medical experiments on non-German nationals, both prisoners of war and civilians, including Jews and *asocial* persons, were carried out on a large scale in Germany and the occupied countries. These experiments were not the isolated and casual acts of individual doctors and scientists working solely on their own responsibility, but were the product of coordinated policy-making and planning at high governmental, military, and Nazi Party levels, conducted as an integral part of the total war effort. They were ordered, sanctioned, permitted, or approved by persons in positions of authority who under all principles of law were under the duty to know about these things and to take steps to terminate or prevent them.

B. Permissible Medical Experiments

The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles[71] must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form or constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an under-standing and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there

[71] Added. The 10 principles set forth here have come to be known as the *Nürnberg Code.*

should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random or unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results will justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability, or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required, through all stages of the experiment, of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he or she has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment, the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

Of the 10 principles which have been enumerated our judicial concern, of course, is with those requirements which are purely legal in nature -- or which at least are so clearly related to matters legal that they assist us in determining criminal culpability and punishment. . . . We find from the evidence that in the medical experiments which have been proved, these ten principles were much more frequently honored in their breach than in their observance. Many of the concentration camp inmates who were the victims of these atrocities were citizen of countries other than the German Reich. They were non-German nationals, including Jew and *asocial persons*, both prisoners of war and civilians, who had been imprisoned and forced to submit to these tortures and barbarities without so much as a semblance of trial. In every single instance appearing in the record, subjects were used who did not consent to the experiments. . . . In no case was the experimental subject at liberty of his own free choice to withdraw from any experiment. In many cases experiments were performed by unqualified persons; were conducted at random for no adequate scientific reason, and under revolting physical conditions. . . . In every one of the experiments the subjects experienced extreme pain or torture, and in most of them they suffered permanent injury, mutilation, or death, either as a direct result of the experiments or because of lack of adequate follow-up care.

Obviously all of these experiments involving brutalities, tortures, disabling injury and death were performed in complete disregard of international conventions, the laws and customs of war, the general principles of criminal law as derived from the criminal laws of all civilized nations, and Control Council Law No. 10. Manifestly, human experiments under such conditions are contrary to "the principles of the law of nations as they result from the usages established among civilized peoples, from the laws of humanity, and from the dictates of public conscience."

Whether any of the defendants in the dock are guilty of these atrocities is, of course, another question.

Under the Anglo-Saxon system of jurisprudence every defendant in a criminal case is presumed to be innocent of an offense charged until the prosecution, by competent, credible proof, has shown his guilt to the exclusion of every reasonable doubt. And, this presumption abides with a defendant through each stage of his trial until such degree of proof has been adduced. A *reasonable doubt* as the name implies is one conformable to reason -- a doubt which a reasonable man would entertain. Stated differently, it is that state of a case which, after a full and complete comparison and consideration of all the evidence, would leave an unbiased, unprejudiced, reflective person, charged with the responsibility for decision, in the state of mind that he could not say that he felt an abiding conviction amounting to a moral certainty of the truth of the charge.

If any of the defendants are to be found guilty under counts two or three of the indictment it must be because the evidence has shown beyond a reasonable doubt that such defendant, without regard to nationality or the capacity in which he acted,

participated as a principal in, accessory to, ordered, abetted, took a consenting part in, or was connected with plans or enterprises involving the commission of at least some of the medical experiments and other atrocities which are the subject matter of these counts. Under no other circumstances may he be convicted.

. . .

VI. Sentences

Presiding Judge Beals: Military Tribunal I has convened this morning for the purpose of imposing sentences upon the defendants who have been on trial before this Tribunal and who have been adjudged guilty by the Tribunal.

Karl Brandt, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Karl Brandt, to death by hanging.

Siegfried Handloser, Military Tribunal I has found and adjudged you guilty of war crimes and crimes against humanity, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Siegfried Handloser, to imprisonment for the full term and period of your natural life, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

Oskar Schroeder, Military Tribunal I has found and adjudged you guilty of war crimes and crimes against humanity, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Oskar Schroeder, to imprisonment for the full term and period of your natural life, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

Karl Genzken, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Karl Genzken, to imprisonment for the full term and period of your natural life, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

Karl Gebhardt, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared

criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Karl Gebhardt, to death by hanging.

Rudolf Brandt, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Rudolf Brandt, to death by hanging.

Joachim Mrugowsky, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Joachim Mrugowsky, to death by hanging.

Helmut Poppendick, Military Tribunal I has found and adjudged you guilty of membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crime on which you have been and now stand convicted Military Tribunal I sentences you, Helmut Poppendick, to imprisonment for the full term and period of your natural life, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

Wolfram Sievers, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Wolfram Sievers, to death by hanging.

Gerhard Rose, Military Tribunal I has found and adjudged you guilty of war crimes and crimes against humanity, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Gerhard Rose, to imprisonment for the full term and period of your natural life, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

Viktor Brack, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been

and now stand convicted Military Tribunal I sentences you, Viktor Brack, to death by hanging.

Waldemar Hoven, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Waldemar Hoven, to death by hanging.

Wilhelm Beigleboeck, Military Tribunal I has found and adjudged you guilty of war crimes and crimes against humanity, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Wilhelm Beiglboeck, to imprisonment for a term of 15 years, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

Herta Oberheuser, Military Tribunal I has found and adjudged you guilty of war crimes and crimes against humanity, as charged under the indictment heretofore filed against you. For your said crimes on which you have been and now stand convicted Military Tribunal I sentences you, Herta Oberheuser, to imprisonment for a term of 20 years, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

Fritz Fischer, Military Tribunal I has found and adjudged you guilty of war crimes, crimes against humanity, and membership in an organization declared criminal by the judgment of the International Military Tribunal, as charged under the indictment heretofore filed against you. For your said crimes, on which you have been and now stand convicted, Military Tribunal I sentences you, Fritz Fischer, to imprisonment for the full term and period of your natural life, to be served at such prison or prisons, or other appropriate place of confinement, as shall be determined by competent authority.

VACCO v. QUILL

Supreme Court of the United States, 1997
521 U.S. 793

Opinion by Chief Justice Rehnquist.

In New York, as in most states, it is a crime to aid another to commit or attempt suicide, but patients may refuse even lifesaving medical treatment. The question presented by this case is whether New York's prohibition on assisting suicide therefore violates the Equal Protection Clause of the Fourteenth Amendment. . . .

Petitioners are various New York public officials. Respondents Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman are physicians who practice in New York. They assert that although it would be "consistent with the standards of [their] medical practices" to prescribe lethal medication for "mentally competent, terminally ill patients" who are suffering great pain and desire a doctor's help in taking their own lives, they are deterred from doing so by New York's ban on assisting suicide. Respondents, and three gravely ill patients who have since died, sued the Attorney General [of New York State] in the United States District Court. They urged that because New York permits a competent person to refuse life-sustaining medical treatment, and because the refusal of such treatment is *essentially the same thing* as physician-assisted suicide, New York's assisted-suicide ban violates the Equal Protection Clause. *Quill v. Koppell,* 870 F. Supp. 78 (1994).

The District Court disagreed: "It is hardly unreasonable or irrational for the state to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." The court noted New York's "obvious legitimate interests in preserving life, and in protecting vulnerable persons," and concluded that "under the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the state." *Id.* at 84 and 85.

The Court of Appeals for the Second Circuit reversed; 97 F.3d 708 (1996). [It] determined that, despite the assisted-suicide ban's apparent general applicability, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths," because "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." In the court's view, "the ending of life by [the withdrawal of life-support systems] is *nothing more nor less than assisted suicide.*" The Court of Appeals then examined whether this supposed unequal treatment was rationally related to any legitimate state interests, and concluded that "to the extent that [New

York's statutes] prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." We granted certiorari.

The Equal Protection Clause commands that no state shall "deny to any person within its jurisdiction the equal protection of the laws." This provision creates no substantive rights. Instead, it embodies a general rule that states must treat like cases alike but may treat unlike cases accordingly. If a legislative classification or distinction "neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end." *Romer* v. *Evans*, 517 U.S 620 (1996).

New York's statutes outlawing assisting suicide affect and address matters of profound significance to all New Yorkers alike. They neither infringe fundamental rights nor involve suspect classifications. These laws are therefore entitled to a strong presumption of validity. *Heller v. Doe,* 509 U.S. 312 (1993).

On their faces, neither New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently than anyone else or draw any distinctions between persons. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide. . . . The Court of Appeals, however, concluded that some terminally ill people -- those who are on life-support systems -- are treated differently than those who are not, in that the former may hasten death by ending treatment, but the latter may not hasten death through physician-assisted suicide. This conclusion depends on the submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide." Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession[72] and in our legal traditions, is both important and logical; it is certainly rational.

The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. . . .

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the

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[72] The American Medical Association emphasizes the "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment." American Medical Association, Council on Ethical and Judicial Affairs, "Physician-Assisted Suicide," 10 *Issues in Law & Medicine* 91, 93 (1994); see also American Medical Association, Council on Ethical and Judicial Affairs, Decisions Near the End of Life, 267 *JAMA* 2229, 2230-2231, 2233 (1992)

patient when [the patient] no longer stands to benefit from them." Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Session, 368 (1996) -- testimony of Dr. Leon R. Kass. The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.* at 367. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not. See, e.g., *In Re Matter of Conroy,* 486 A.2d 1209 (1985) patients, who refuse life-sustaining treatment, "may not harbor a specific intent to die" and may instead "fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs."

The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. *Morissette v. United States,* 342 U.S. 246 (1952) - distinctions based on intent are "universal and persistent in mature systems of law." Put differently, the law distinguishes actions taken *because of* a given end from actions taken *in spite of* their unintended but foreseen consequences. *Personal Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 279 (1979); "When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death. . . . His purpose, though, was to . . . liberate Europe from the Nazis".

Given these general principles, it is not surprising that many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide. See, e.g., *Fosmire v. Nicoleau,* 75 N. Y. 2d 218 (1990) -- Merely declining medical . . . care is not considered a suicidal act." In fact, the first state-court decision explicitly to authorize withdrawing lifesaving treatment noted the "real distinction between the self-infliction of deadly harm and a self-determination against artificial life support." *In re Quinlan,* 355 A. 2d 647 (1976).

Similarly, the overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter. *Washington v. Glucksberg,* 521 US 702 (1997). And "nearly all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health-care situations, or in living will statutes." *People v. Kevorkian,* 527 N.W.2d 714 (1994). Thus, even as the states move to protect and promote patients' dignity at the end of life, they remain opposed to physician-assisted suicide.

. . .

This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In *Cruzan v. Director, Mo. Dept. of Health,*

497 U.S. 261 (1990), we concluded that "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions," and we assumed the existence of such a right for purposes of that case. *Id.* at 278. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract right to hasten death, but on well established, traditional rights to bodily integrity and freedom from unwanted touching. In fact, we observed that "the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Id.* at 280. *Cruzan* therefore provides no support for the notion that refusing life-sustaining medical treatment is "nothing more nor less than suicide."

For all these reasons, we disagree with respondents' claim that the distinction between refusing lifesaving medical treatment and assisted suicide is "arbitrary" and *irrational.* Granted, in some cases, the line between the two may not be clear, but certainty is not required, even were it possible. logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York's reasons for recognizing and acting on this distinction -- including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia -- are discussed in greater detail in our opinion in *Glucksberg*. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.

The judgment of the Court of Appeals is reversed.

WASHINGTON v. GLUCKSBERG

Supreme Court of the United States, 1997
521 U.S. 702

Chief Justice Rehnquist delivered the opinion of the Court.[73] . . .

The question presented in this case is whether Washington [State's] prohibition against *causing* or *aiding* a suicide offends the Fourteenth Amendment to the United States Constitution. . . .

It has always been a crime to assist a suicide in the State of Washington. In 1854, Washington's first Territorial Legislature outlawed "assisting another in the commission of self-murder." [74] Today, Washington law provides: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." Wash. Rev. Code 9A.36.060(1) (1994). "Promoting a suicide attempt" is a felony, punishable by up to five years' imprisonment and up to a $10,000 fine. §9 A.36.060(2) and §9 A.20.021(1)(c). At the same time, Washington's Natural Death Act, enacted in 1979, states that the "withholding or withdrawal of life-sustaining treatment" at a patient's direction "shall not, for any purpose, constitute a suicide." Wash. Rev. Code §70.122.070(1).[75]

Petitioners in this case are the State of Washington and its Attorney General. Respondents Harold Glucksberg, M. D., Abigail Halperin, M. D., Thomas A. Preston, M. D., and Peter Shalit, M. D., are physicians who practice in Washington. These doctors occasionally treat terminally ill, suffering patients, and declare that they would assist these patients in ending their lives if not for Washington's assisted-suicide ban. In January 1994, respondents, along with three gravely ill, pseudonymous plaintiffs [all of whom declared that they were mentally competent and desired assistance in ending their

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[73] Added from the body of the case. Chief Justice Rehnquist delivered the opinion of the Court in which Justices O'Connor, Scalia, Kennedy, and Thomas joined. Justice O'Connor filed a concurring opinion, in which Justices Ginsburg and Breyer joined in part. Justices Stevens, Souter, Ginsburg, and Breyer, filed opinions concurring in the judgment.

[74] Act of Apr. 28, 1854, §17, 1854 Wash. Laws 78. "Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter"

[75] Under Washington's Natural Death Act, "adult persons have the fundamental right to control the decisions relating to the rendering of their own healthcare, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition." Wash. Rev. Code §70.122.010 (1994). In Washington, "any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition," §70.122.030, and a physician who, in accordance with such a directive, participates in the withholding or withdrawal of life-sustaining treatment is immune from civil, criminal, or professional liability. §70.122.051.

lives and who have since died,] . . . and Compassion in Dying, a nonprofit organization that counsels people considering physician-assisted suicide, sued in the United States District Court, seeking a declaration that Wash. Rev. Code 9A.36.060(1) (1994) is, on its face, unconstitutional.

The plaintiffs asserted "the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide." Relying primarily on *Planned Parenthood v. Casey,* 505 U.S. 833 (1992), and *Cruzan v. Director, Missouri Dept. of Health,* 497 U.S. 261 (1990), the District Court agreed, and concluded that Washington's assisted-suicide ban is unconstitutional because it "places an undue burden on the exercise of [that] constitutionally protected liberty interest," quoting *Cleburne v. Bleburne Living Center, Inc.*, 473 U.S. 432 (1985). The District Court also decided that the Washington statute violated the Equal Protection Clause's requirement that "'all persons similarly situated . . . be treated alike.'"

A panel of the Court of Appeals for the Ninth Circuit reversed, emphasizing that "in the 205 years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction." The Ninth Circuit reheard the case *en banc,* reversed the panel's decision, and affirmed the District Court, . . . emphasiz[ing] our *Casey* and *Cruzan* decisions. The court also discussed what it described as *historical* and *current societal attitudes* toward suicide and assisted suicide and concluded that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death -- that there is, in short, a constitutionally-recognized *right to die.*" After *weighing* and then *balancing* this interest against Washington's various interests, the court held that the state's assisted-suicide ban was unconstitutional "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." The court did not reach the District Court's equal-protection holding. . . .

I. [Historical Background]

We begin, as we do in all due-process cases, by examining our nation's history, legal traditions, and practices. In almost every state -- indeed, in almost every western democracy -- it is a crime to assist a suicide.[76] The states' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the states' commitment to the protection and preservation of all human life. *Cruzan, supra.* "The states -- indeed, all civilized nations -- demonstrate their commitment to life by treating homicide as a

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[76] In total, 44 [now, 47] states, the District of Columbia and two territories prohibit or condemn assisted suicide. For a detailed history of the states' statutes, see Marzen, O'Dowd, Crone & Balch, "Suicide: A Constitutional Right?" 24 *Duquesne L. Rev.* 1, 148-242 (1985) (Appendix) (hereinafter Marzen).

[In a Canadian case], *Rodriguez v. British Columbia (Attorney General),* 107 D. L. R. (4th) 342 (1993), the court looked at the rule in other countries: "A blanket prohibition on assisted suicide . . . is the norm among western democracies" -- discussing assisted-suicide provisions in Austria, Spain, Italy, the United Kingdom, the Netherlands, Denmark, Switzerland, and France.

serious crime. Moreover, the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide"; see *Stanford v. Kentucky,* 492 U.S. 361, 373 (1989). Indeed, opposition to and condemnation of suicide -- and, therefore, of assisting suicide -- are consistent and enduring themes of our philosophical, legal, and cultural heritages. See generally, Marzen, O'Dowd, Crone & Balch, "Suicide: A Constitutional Right?" 24 *Duquesne L. Rev.* 1, 17-56 (1985) and New York State Task Force on Life and the Law, "When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context" (May 1994).

More specifically, for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide.[77] *Cruzan, supra.* In the 13th Century, Henry de Bracton, one of the first legal-treatise writers, observed that "just as a man may commit felony by slaying another so may he do so by slaying himself." 2 Bracton *On Laws and Customs of England* 423 (f. 150) (G. Woodbine ed., S. Thorne translator, 1968). The real and personal property of one who killed himself to avoid conviction and punishment for a crime were forfeit to the king; however, thought Bracton, "if a man slays himself in weariness of life or because he is unwilling to endure further bodily pain . . . [only] his movable goods [were] confiscated Thus, "the principle that suicide of a sane person, for whatever reason, was a punishable felony was . . . introduced into English common law."[78] Centuries later, Sir William Blackstone, whose *Commentaries on the Laws of England* not only provided a definitive summary of the common law but was also a primary legal authority for 18th and 19th Century American lawyers, referred to suicide as *self-murder* and "the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure . . . ." 4 W. Blackstone, *Commentaries* 189. Blackstone emphasized that "the law has . . . ranked [suicide] among the highest crimes," although, anticipating later developments, he conceded that the harsh and shameful punishments imposed for suicide "border a little upon severity."

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[77] The common law is thought to have emerged through the expansion of pre-Norman institutions sometime in the 12th Century. J. Baker, *An Introduction to English Legal History* (2d ed. 1979). England adopted the ecclesiastical prohibition on suicide five centuries earlier, in the year 673 at the Council of Hereford, and this prohibition was reaffirmed by King Edgar in 967. See G. Williams, *The Sanctity of Life and the Criminal Law* (1957).

[78] [According to Marzen] [o]ther late-medieval treatise writers followed and restated Bracton; one observed that *man-slaughter* may be "of oneself; as in case, when people hang themselves or hurt themselves, or otherwise kill themselves of their own felony" or "of others; as by beating, famine, or other punishment; in like cases, all are man-slayers." A. Horne, *The Mirrour of Justices*, ch. 1, §9 (W. Robinson ed. 1903). By the mid-16th century, the Court at Common Bench could observe that "[suicide] is an Offence against Nature, against God, and against the King. . . . To destroy one's self is contrary to Nature, and a Thing most horrible." *Hales* v. *Petit*, 75 Eng. Rep. 387 (1561-1562).

In 1644, Sir Edward Coke published his Third Institute, a lodestar for later common lawyers. See T. Plucknett, *A Concise History of the Common Law* 281-284 (5th ed. 1956). Coke regarded suicide as a category of murder and agreed with Bracton that the goods and chattels -- but not, for Coke, the lands --of a sane suicide were forfeit.

For the most part, the early American colonies adopted the common-law approach. For example, the legislators of the Providence Plantations, which would later become Rhode Island, declared, in 1647, that "self-murder is by all agreed to be the most unnatural, and it is by this present Assembly declared, to be that, wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor: . . . his goods and chattels are the king's custom, but not his debts nor lands; but in case he be an infant, a lunatic, mad or distracted man, he forfeits nothing." *The Earliest Acts and Laws of the Colony of Rhode Island and Providence Plantations* 1647-1719, p. 19 (J. Cushing ed. 1977). Virginia also required ignominious burial for suicides, and their estates were forfeit to the crown. A. Scott, *Criminal Law in Colonial Virginia* 108, and n.15 and n.93 (1930).

Over time, however, the American colonies abolished these harsh common-law penalties. William Penn abandoned the criminal-forfeiture sanction in Pennsylvania in 1701, and the other colonies (and later, the other states) eventually followed this example. Zephaniah Swift, who would later become Chief Justice of Connecticut, wrote in 1796 that --

> [T]here can be no act more contemptible, than to attempt to punish an offender for a crime, by exercising a mean act of revenge upon lifeless clay, that is insensible of the punishment. There can be no greater cruelty, than the inflicting [of] a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender. . . . [Suicide] is so abhorrent to the feelings of mankind, and that strong love of life which is implanted in the human heart, that it cannot be so frequently committed, as to become dangerous to society. There can of course be no necessity of any punishment. Z. Swift, *A System of the Laws of the State of Connecticut* 304 (1796).

This statement makes it clear, however, that the movement away from the common law's harsh sanctions did not represent an acceptance of suicide; rather, as Chief Justice Swift observed, this change reflected the growing consensus that it was unfair to punish the suicide's family for his wrongdoing. Nonetheless, although states moved away from Blackstone's treatment of suicide, courts continued to condemn it as a grave public wrong.

That suicide remained a grievous, though nonfelonious, wrong is confirmed by the fact that colonial and early state legislatures and courts did not retreat from prohibiting assisting suicide. Swift, in his early 19th Century treatise on the laws of Connecticut, stated that "if one counsels another to commit suicide, and the other by reason of the advice kills himself, the advisor is guilty of murder as principal." Z. Swift, *A Digest of the Laws of the State of Connecticut* 270 (1823). This was the well established common law view, see *In re Joseph G.*, 667 P. 2d 1176 (1983); *Commonwealth v. Mink,* 123 Mass. 422 (1877). [Also] the prohibitions against assisting suicide never contained exceptions for those who were near death. . . .

The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828, (codified at 2 N. Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, §7, p. 661 (1829)), and many of the new states and territories followed New York's example. Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited *aiding* a suicide and, specifically, "furnishing another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life." Marzen at 76-77. By the time the Fourteenth Amendment was ratified, it was a crime in most states to assist a suicide. . . .

Though deeply rooted, the states' assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed. Because of advances in medicine and technology, Americans today are increasingly likely to die in institutions, from chronic illnesses. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment,* 16-18 (1983). Public concern and democratic action are therefore sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in state laws and in the attitudes these laws reflect. Many states, for example, now permit living wills, surrogate healthcare decision-making, and the withdrawal or refusal of life-sustaining medical treatment. See *Vacco* v. *Quill*, 97 F.3d 708 (1996); *People v. Kevorkian,* 527 N.W.2d 714 (MI, 1994). At the same time, however, voters and legislators continue for the most part to reaffirm their states' prohibitions on assisting suicide.

The Washington statute at issue in this case, Wash. Rev. Code §9A.36.060 (1994), was enacted in 1975 as part of a revision of that state's criminal code. Four years later, Washington passed its Natural Death Act, which specifically stated that the "withholding or withdrawal of life-sustaining treatment . . . shall not, for any purpose, constitute a suicide" and that "nothing in this chapter shall be construed to condone, authorize, or approve mercy killing Wash. Rev. Code §70.122.070(1), §70.122.100 (1994)). In 1991, Washington voters rejected a ballot initiative which, had it passed, would have permitted a form of physician-assisted suicide. Washington then added a provision to the Natural Death Act expressly excluding physician-assisted suicide. Wash. Rev. Code §70.122.100 (1994).

. . .

Thus, the states are currently engaged in serious, thoughtful examinations of physician-assisted suicide and other similar issues.[79] For example, New York State's

[79] Other countries are embroiled in similar debates: The Supreme Court of Canada recently rejected a claim that the Canadian Charter of Rights and Freedoms establishes a fundamental right to assisted suicide, *Rodriguez v. British Columbia*, 107 D.L.R. (4th) 342 (1993); the British House of Lords Select Committee on Medical Ethics refused to recommend any change in Great Britain's assisted-suicide prohibition, House of Lords, "Session 1993-94 Report of the Select Committee on Medical Ethics, 12 *Issues in Law & Med.* 193 (1996); New Zealand's Parliament rejected a proposed 'Death With Dignity Bill' that would have legalized physician-assisted suicide in August 1995, Graeme, "MPs Throw out Euthanasia Bill," *The Dominion* (Wellington), Aug. 17, 1995; but the Northern Territory of Australia legalized assisted suicide and voluntary

Task Force on Life and the Law -- an ongoing, blue-ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen -- was convened in 1984 and commissioned with "a broad mandate to recommend public policy on issues raised by medical advances." Over the past decade, the Task Force has recommended laws relating to end-of-life decisions, surrogate pregnancy, and organ donation. After studying physician-assisted suicide, however, the Task Force unanimously concluded that "legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. . . . The potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved."

Attitudes toward suicide itself have changed since Bracton, but our laws have consistently condemned, and continue to prohibit, assisting suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decision-making, we have not retreated from this prohibition. Against this backdrop of history, tradition, and practice, we now turn to respondents' constitutional claim.

II. [Is There a Right to Assisted Suicide?]

. . .

We now inquire whether this asserted right [to assisted suicide] has any place in our nation's traditions. . . . [We] are confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults. To hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every state.

Respondents contend . . . that the liberty interest they assert *is* consistent with this Court's substantive-due-process line of cases, if not with this nation's history and practice. . . . The question presented in this case, however, is whether the protections of the Due Process Clause include a right to commit suicide with another's assistance.

In *Cruzan*, we considered whether Nancy Beth Cruzan, who had been severely injured in an automobile accident and was in a persistent vegetative state, "had a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment" at her parents' request. . . . [W]e concluded that "the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.". . . [N]otwithstanding this right, the

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euthanasia in 1995. See Shenon, "Australian Doctors Get Right to Assist Suicide," *N.Y. Times*, July 28, 1995. . . . On March 24, 1997, however, the Australian Senate voted to overturn the Northern Territory's law. Thornhill, "Australia Repeals Euthanasia Law," *Washington Post*, March 25, 1997. On the other hand, on May 20, 1997, Colombia's Constitutional Court legalized voluntary euthanasia for terminally ill people. Sentencia No. C-239/97 (Corte Constitucional, Mayo 20, 1997); see "Colombia's Top Court Legalizes Euthanasia," *Orlando Sentinel*, May 22, 1997.

Constitution permitted Missouri to require clear and convincing evidence of an incompetent patient's wishes concerning the withdrawal of life-sustaining treatment.

Respondents contend that in *Cruzan* we "acknowledged that competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death," and that "the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication." Similarly, the Court of Appeals concluded that "*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognized a liberty interest in hastening one's own death."

. . . The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. In *Cruzan* itself, we recognized that most states outlawed assisted suicide -- and even more do today -- and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide.

. . .

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted *right* to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests. This requirement is unquestionably met here.[80] As the court below recognized, Washington's assisted-suicide ban implicates a number of state interests.

First, Washington has an "unqualified interest in the preservation of human life." *Cruzan, supra.* The state's prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest This interest is symbolic and aspirational as well as practical:

> While suicide is no longer prohibited or penalized, the ban against assisted suicide and euthanasia shores up the notion of limits in human relationships. It reflects the gravity with which we view the decision to

[80] The court identified and discussed six state interests: 1) preserving life; 2) preventing suicide; 3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence; 4) protecting family members and loved ones; 5) protecting the integrity of the medical profession; and 6) avoiding future movement toward euthanasia and other abuses.

take one's own life or the life of another, and our reluctance to encourage or promote these decisions. New York Task Force 131-132.

Respondents admit that "the state has a real interest in preserving the lives of those who can still contribute to society and enjoy life." The Court of Appeals also recognized Washington's interest in protecting life, but held that the *weight* of this interest depends on the "medical condition and the wishes of the person whose life is at stake." Washington, however, has rejected this sliding-scale approach and, through its assisted-suicide ban, insists that all persons' lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law. See *United States v. Rutherford,* 442 U.S. 544, 558 (1979); ". . . Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self-styled panaceas that inventive minds can devise." As we have previously affirmed, the states "may properly decline to make judgments about the *quality* of life that a particular individual may enjoy," *Cruzan, supra,* at 282. This remains true, as *Cruzan* makes clear, even for those who are near death.

. . .

Those who attempt suicide -- terminally ill or not -- often suffer from depression or other mental disorders. Research indicates, however, that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated. . . . [B]ecause depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs. Thus, legal physician-assisted suicide could make it more difficult for the state to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.

The state also has an interest in protecting the integrity and ethics of the medical profession. In contrast to the Court of Appeals' conclusion that "the integrity of the medical profession would [not] be threatened in any way by [physician-assisted suicide]," the American Medical Association, like many other medical and physicians' groups, has concluded that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." American Medical Association, Code of Ethics §2.211 (1994). And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming.

Next, the state has an interest in protecting vulnerable groups -- including the poor, the elderly, and disabled persons -- from abuse, neglect, and mistakes. The Court of Appeals dismissed the state's concern that disadvantaged persons might be pressured into physician-assisted suicide as *ludicrous on its face*. We have recognized, however, the real risk of subtle coercion and undue influence in end-of-life situations. *Cruzan, supra,* at 281. . . . The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to

good medical care, advanced age, or membership in a stigmatized social group. If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.

. . .

Finally, the state may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. . . . The Court of Appeals' decision, and its expansive reasoning, provide ample support for the state's concerns. The court noted, for example, that the "decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself," that "in some instances, the patient may be unable to self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them; and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. Thus, it turns out that what is couched as a limited right to *physician-assisted* suicide is likely, in effect, a much broader license, which could prove extremely difficult to police and contain. Washington's ban on assisting suicide prevents such erosion.

This concern is further supported by evidence about the practice of euthanasia in the Netherlands. The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as "the deliberate termination of another's life at his request"), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent. *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady*, at 12-13 (citing Dutch study). This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia.

. . . [Following the Court of Appeals,] [w]e therefore hold that Wash. Rev. Code §9A.36.060(1) (1994) does not violate the Fourteenth Amendment, either on its face or "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors."

Throughout the nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society. The decision of the *en banc* Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

IN THE MATTER OF WESTCHESTER COUNTY MEDICAL CENTER ON BEHALF OF MARY O'CONNOR

Court of Appeals of New York, 1988
531 N.E.2d 607

Opinion by Chief Judge Wachtler. . . .

Mary O'Connor is an elderly hospital patient who, as a result of several strokes, is mentally incompetent and unable to obtain food or drink without medical assistance. In this dispute between her daughters and the hospital, the question is whether the hospital should be permitted to insert a nasogastric tube to provide her with sustenance or whether, instead, such medical intervention should be precluded and she should be allowed to die because, prior to becoming incompetent, she made several statements to the effect that she did not want to be a burden to anyone and would not want to live or be kept alive by artificial means if she were unable to care for herself.

The hospital has applied for court authorization to insert the nasogastric tube. The patient's daughters object claiming that it is contrary to her expressed wishes. . . . The trial court denied the hospital's application, concluding that it was contrary to the patient's wishes. The Appellate Division affirmed, with two justices dissenting. The hospital has appealed . . . by leave of the Appellate Division [and a stay has been granted] . . . permitting the patient to be fed intravenously while this appeal is pending.

. . .

I. [Facts]

The patient is a 77-year-old widow with two children, Helen and Joan, both of whom are practical nurses. After her husband's death in 1967, she lived alone in her apartment in the New York City area where she was employed in hospital administration. In 1983, she retired from her job after 20 years service.

Over the years, a number of her close relatives died of cancer. . . .

In July of the following year she suffered the first of a series of strokes causing brain damage and related disabilities which rendered her unable to care for herself. She became passive, could only carry on limited conversations, and could not walk, eat, dress or care for her bodily needs without assistance from others. Upon her release from the hospital in August 1985, Mrs. O'Connor resided with her daughter Helen who, together with Joan and another woman, provided her with full-time care.

In December 1987, Mrs. O'Connor had a second major stroke causing additional physical and mental disabilities. She became unresponsive and unable to stand or feed

herself. She had to be spoon-fed by others. Her gag reflex was also impaired, as a result of which she experienced difficulty swallowing and, thus, could eat only pureed foods. In this condition, her daughters found that they could no longer care for her at home and, when she left the hospital in February 1988, she was transferred to the Ruth Taylor Institute (hereinafter the Institute), a long-term geriatric care facility associated with the Westchester County Medical Center (hereinafter the hospital). In conjunction with this transfer, her daughters submitted a document signed by both of them, to be included in her medical file, stating that their mother had expressed the wish in many conversations that "no artificial life support be started or maintained in order to continue to sustain her life," and that they wanted this request to be honored.

During the initial part of her stay at the Institute the staff found Mrs. O'Connor was cooperative, capable of sitting in a chair and interacting with her surroundings. However, in June her condition deteriorated. She became "stuperous, virtually non-responsive" and developed a fever. On June 20, 1988, she was transferred from the Institute to the hospital.

At the hospital, it was determined that she was suffering from dehydration, sepsis and, probably, pneumonia. The hospital staff also found that she had lost her gag reflex, making it impossible for her to swallow food or liquids without medical assistance. She showed marked improvement after receiving fluids, limited nourishment and antibiotics intravenously. Within a few days she became alert, able to follow simple commands and [able to] respond verbally to simple questions. However, her inability to swallow persisted and her physician, Dr. Sivak, determined that a nasogastric tube should be used to provide more substantial nourishment. When Mrs. O'Connor's daughters objected to this procedure, the matter was brought before the hospital's ethics committee which found that it would be inappropriate to withhold this treatment under the circumstances.

On July 15, the hospital . . . [sought] authorization to use the nasogastric tube, claiming that without this relief Mrs. O'Connor would die of thirst and starvation within a few weeks. In an opposing affidavit, her daughters stated that this was against their mother's expressed wishes because, before becoming incompetent, she had repeatedly stated that she did not want her life prolonged by artificial means if she was unable to care for herself. They noted the number of relatives she had comforted during prolonged final illnesses and urged that the effect of her statements should be evaluated against that background.

The hearing on the petition began on July 19 and concluded on July 21. Two medical experts testified regarding Mrs. O'Connor's condition: Dr. Sivak for the hospital and Dr. Wasserman for the respondents. With respect to the patient's statements concerning life-sustaining measures, the respondents themselves both testified and called one additional witness, James Lampasso.

The treating physician, Dr. Sivak, testified that Mrs. O'Connor was suffering from multi-infarct dementia as a result of the strokes. This condition substantially impaired her cognitive ability but she was not in a coma or vegetative state. She was conscious and capable of responding to simple questions or requests, sometimes by squeezing the questioner's hand and sometimes verbally. She was also able to respond to noxious stimuli, such as a needle prick, . . . although she was not experiencing pain in her present condition. When asked how she felt she usually responded fine, *all right*, or *okay*. The treating physician also testified that her mental awareness had improved at the hospital and that she might become more alert in the future. In fact during the latest examination conducted that morning, in response to the doctor's request she had attempted to sit up and had been able to roll over on her side so that he could examine her lungs. However, Dr. Sivak stated that she is unable to comprehend complex questions, such as those dealing with her medical treatment, and doubted that she would ever regain significant mental capacity because the brain damage was substantial and irreparable.

The doctor stated that Mrs. O'Connor was presently receiving nourishment exclusively through intravenous feeding. However, this procedure was inadequate for long-term use because it does not provide sufficient nutrients and the veins tend to deteriorate. . . . [A gastric tube connected to her digestive tract thorough her nose or abdomen] would provide adequate nutrients and would cause only transient discomfort at the time of insertion. Since the patient's condition is otherwise fairly stable, this procedure would preserve her life for several months, perhaps several years. If the procedure were not employed and the intravenous methods could no longer be used or were otherwise discontinued, she would die of thirst and starvation within 7 to 10 days. The doctor stated that death from starvation and especially thirst, was a painful way to die and that Mrs. O'Connor would, therefore, experience extreme, intense discomfort since she is conscious, alert, capable of feeling pain, and sensitive to even mild discomfort.

The respondents' expert Dr. Wasserman, a neurologist, agreed essentially with Dr. Sivak's evaluation and prognosis. In his opinion, however, Mrs. O'Connor would not experience pain if permitted to die of thirst and starvation. Because of the extensive brain damage she had suffered, the doctor did not "think she would react as you or I would under the circumstances" but would simply become more lethargic, unresponsive, and would ultimately die. If she experienced pain he believed she could be given pain killers to alleviate it. He conceded, however, that he could not be medically certain that she would not suffer because he had never had a patient, or heard of one, dying after being deprived of food and water. Thus, he candidly admitted: "I guess we don't know."

Interestingly, Dr. Wasserman also admitted that during his examination, which occurred just before the close of the hearing, the patient exhibited further improvement in her condition. He found that she was generally able to respond to simple commands, such as a request to move her arm or foot. He also noted that she was able to state her

name, seemed to be aware of where she was, and responded to questions about 50 or 60 percent of the time, although her speech was slow and halting and her responses were not always appropriate. Most significantly, she was able to converse in short sentences of two or three words which, he noted, she had not been able to do since her admission to the hospital. He also observed that she had a gag reflex. Although he did not know whether Mrs. O'Connor would be able to use it to eat, he recognized the possibility that she might.

Neither of the doctors had known Mrs. O'Connor before she became incompetent and, thus, knew nothing of her attitudes toward the use of life-sustaining measures. The respondents' first witness on this point was James Lampasso, a former co-worker and longtime friend of Mrs. O'Connor. . . . He testified that his first discussion with Mrs. O'Connor concerning artificial means of prolonging life occurred about 1969. At that time his father, who was dying of cancer, informed him that he would not want to continue life by any artificial method if he had lost his dignity because he could no longer control his normal bodily functions. The witness said that when he told Mrs. O'Connor of this she agreed wholeheartedly and said: "I would never want to be a burden on anyone and I would never want to lose my dignity before I passed away." He noted that she was a very religious woman who "felt that nature should take its course and not use further artificial means." They had similar conversations on two or three occasions between 1969 and 1973. During these discussions Mrs. O'Connor variously stated that it is monstrous to keep someone alive by using "machinery, things like that" when they are "not going to get better"; that she would never want to be in the same situation as her husband and Mr. Lampasso's father and that people who are "suffering very badly" should be allowed to die.

Mrs. O'Connor's daughter Helen testified that her mother informed her on several occasions that if she became ill and was unable to care for herself she would not want her life to be sustained artificially. The first discussion occurred after her husband was hospitalized with cancer in 1967. At that time, Mrs. O'Connor said that she never wanted to be in a similar situation and that she would not want to go on living if she could not "take care of herself and make her own decisions." The last discussion occurred after Mrs. O'Connor's stepmother died of cancer, and Mrs. O'Connor was hospitalized for a heart attack: "My mother said that she was very glad to be home, very glad to be out of the hospital and [hoped] she would never have to be back in one again and would never want any sort of intervention -- any sort of life support systems -- to maintain or prolong her life." Mrs. O'Connor's other daughter, Joan, essentially adopted her sister's testimony. . . .

. . . [A]ll three of these witnesses also agreed that Mrs. O'Connor had never discussed providing food or water with medical assistance, nor had she ever said that she would adhere to her view and decline medical treatment by artificial means if that would produce a painful death. When Helen was asked what choice her mother would make under those circumstances she admitted that she did not know. Her sister Joan agreed. . . .

. . .

II. [Analysis of Law]

It has long been the common-law rule in this state that a person has the right to decline medical treatment, even lifesaving treatment, absent an overriding state interest. *Schloendorff v. Society of N. Y. Hospital,* 105 N.E. 92 (1914). In 1981, we held, in two companion cases, that a hospital or medical facility must respect this right even when a patient becomes incompetent, if while competent, the patient stated that he or she did not want certain procedures to be employed under specified circumstances. *Matter of Storar and Matter of Eichner v. Dillon,* 52 N.Y.2d 363, cert denied 454 U.S. 858 (1981). In *Storar*, a case involving a retarded adult suffering from terminal cancer, who needed blood transfusions to keep him from bleeding to death, we declined to direct termination of the treatment because it was impossible to determine what his wish would have been were he competent and it would be improper for a court to substitute its judgment for the unascertainable wish of the patient. Commenting on this latter principle in a subsequent case we noted that the right to decline treatment is personal and, under existing law in this state, could not be exercised by a third party when the patient is unable to do so. *People v. Eulo,* 63 N.Y.2d 341 (1984).[81]

In contrast to the patient in *Storar*, the patient in *Eichner* had been competent and capable of expressing his will before he was silenced by illness. In those circumstances, we concluded that it would be appropriate for the court to intervene and direct the termination of artificial life supports, in accordance with the patient's wishes, because it was established by *clear and convincing evidence* that the patient would have so directed if he were competent and able to communicate, at 379, *supra*; see also, *Matter of Delio v. Westchester County Medical Center,* 516 N.Y.S.2d 677 (1980); and *Addington v. Texas,* 441 U.S. 418 (1978). We selected the clear and convincing evidence standard in *Eichner* because it "impresses the factfinder with the importance of the decision . . . and it forbids relief whenever the evidence is loose, equivocal or contradictory" (*Matter of Storar, supra,* at 379). Nothing less than unequivocal proof will suffice when the decision to terminate life supports is at issue.

In *Eichner*, we had no difficulty finding clear and convincing evidence of the patient's wishes. Brother Fox, the patient in *Eichner*, was a member of a religious order who had conscientiously discussed his moral and personal views concerning the use of a respirator on persons in a vegetative state. The conclusion that "he carefully reflected on the subject [was] supported by his religious beliefs and [was] not inconsistent with his life of unselfish religious devotion." (*Id.*, at 379-380.) Further, his expressions were

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[81] Added; moved from the body of the case. The status of the law on this point has since been changed to some extent by legislation. The legislature has now authorized third parties to issue do not resuscitate orders for incompetent patients under certain circumstances (Public Health Law, Article 29-b). More recently the legislature enacted a statute permitting individuals to create springing powers of attorney, which come into effect when another designated person determines that the maker has become incompetent (General Obligations Law §5-1602).

"solemn pronouncements and not casual remarks made at some social gathering, nor could it be said that he was too young to realize or feel the consequences of his statements" (*Id.*, at 380). Indeed, because the facts in Brother Fox's case were so clear, we had no need to elaborate upon the kind of showing necessary to satisfy the clear and convincing standard.

The facts in this case present a much closer question and require us to explore in more detail the application of that standard in this context. . . . [They suggest] some basic principles which may be used in determining whether the proof clearly and convincingly evinces an intention by the patient to reject life prolonged artificially by medical means.

III. [Discussion]

. . . Our focus must always be on what the patient would say if asked today whether the treatment in issue should be terminated. However, we can never be completely certain of the answer to our question, since the inquiry assumes that the patient is no longer able to express his or her wishes. Most often, therefore, the inquiry turns on interpretation of statements on the subject made by the patient in the past. This exercise presents inherent problems.

For example, there always exists the possibility that, despite his or her clear expressions in the past, the patient has since changed his or her mind. And, as Judge Simons in his dissenting opinion correctly points out, human beings are incapable of perfect foresight. . . . In addition, there exists the danger that the statements were made without the reflection and resolve that would be brought to bear on the issue if the patient were presently capable of making the decision.

But the existence of these problems does not lead inevitably to the conclusion that we should abandon the inquiry entirely and adopt as guideposts the objective factors used in the so-called *substituted judgment* approach. See, *Brophy v. New England Sinai Hospital,* 497 N.E.2d 626 (MA, 1986). That approach remains unacceptable because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. *People v Eulo, supra*. . . . [W]e adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.

Every person has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances. *Matter of Storar, supra*. . . . [I]f an error occurs it should be made on the side of life.

Viewed in that light, the clear and convincing evidence standard requires proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life support. . . . The persistence of the individual's statements, the seriousness with which those statements were made and the inferences, if any, that may be drawn from the surrounding circumstances are among the factors which should be considered.

The ideal situation is one in which the patient's wishes were expressed in some form of a writing, perhaps a living will, while he or she was still competent. The existence of a writing suggests the author's seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks. Further, a person who has troubled to set forth his or her wishes in a writing is more likely than one who has not to make sure that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends. In contrast, a person whose expressions of intention were limited to oral statements may not as fully appreciate the need to rescind those statements after a change of heart.

Of course, a requirement of a written expression in every case would be unrealistic. Further, it would unfairly penalize those who lack the skills to place their feelings in writing. For that reason, we must always remain open to applications such as this, which are based upon the repeated oral expressions of the patient. In this case, however, the application must ultimately fail, because it does not meet the foregoing criteria.

Although Mrs. O'Connor's statements about her desire to decline life-saving treatments were repeated over a number of years, there is nothing, other than speculation, to persuade the fact finder that her expressions were more than immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death. Her comments -- that she would never want to lose her dignity before she passed away, that nature should be permitted to take its course, that it is *monstrous* to use life-support machinery -- are, in fact, no different than those that many of us might make after witnessing an agonizing death. Similarly, her statements to the effect that she would not want to be a burden to anyone are the type of statements that older people frequently, almost invariably make. If such statements were routinely held to be clear and convincing proof of a general intent to decline all medical treatment once incompetency sets in, few nursing home patients would ever receive life-sustaining medical treatment in the future. The aged and infirm would be placed at grave risk if the law uniformly, but unrealistically, treated the expression of such sentiments as a calm and deliberate resolve to decline all life-sustaining medical assistance once the speaker is silenced by mental disability. . . .

We do not mean to suggest that, to be effective, a patient's expressed desire to decline treatment must specify a precise condition and a particular treatment. We recognize that human beings are not capable of foreseeing either their own medical

condition or advances in medical technology. Nevertheless, it is relevant to the fundamental question -- the patient's desires -- to consider whether the infirmities she was concerned with, and the procedures she eschewed, are qualitatively different than those now presented. . . .

Thus, it is appropriate for us to consider the circumstances in which Mrs. O'Connor made the statements and to compare them with those which presently prevail.

Her statements with respect to declining artificial means of life support were generally prompted by her experience with persons suffering terminal illnesses, particularly cancer. However, Mrs. O'Connor does not have a terminal illness, except in the sense that she is aged and infirm. Neither is she in a coma nor vegetative state. She is awake and conscious; she can feel pain, responds to simple commands, can carry on limited conversations, and is not experiencing any pain. She is simply an elderly person who as a result of several strokes suffers certain disabilities, including an inability to feed herself or eat in a normal manner. She is in a stable condition and if properly nourished will remain in that condition unless some other medical problem arises. . . .

It is true, of course, that in her present condition she cannot care for herself or survive without medical assistance and that she has stated that she never wanted to be a burden and would not want to live, or be kept alive artificially if she could not care for herself. But no one contends, and it should not be assumed, that she contemplated declining medical assistance when her prognosis was uncertain. Here both medical experts agreed that she will never regain sufficient mental ability to care for herself, but it is not clear from the record that the loss of her gag reflex is permanent and that she will never be able to obtain food and drink without medical assistance.

. . .

[IV. Conclusion]

In sum, . . . it cannot be said that Mrs. O'Connor elected to die under circumstances such as these. Even her daughters, who undoubtedly know her wishes better than anyone, are earnestly trying to carry them out, and whose motives we believe to be of the highest and most loving kind, candidly admit that they do not know what she would do, or what she would want done under these circumstances.

Accordingly the order of the Appellate Division should be reversed. . . .

APPENDIX A

UNITED STATES CONSTITUTION

UNITED STATES CONSTITUTION

ARTICLE I.

Section 1.

All legislative powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives.

Section 2.

1. The House of Representatives shall be composed of members chosen every second year by the people of the several States, and the electors in each State shall have the qualifications requisite for electors of the most numerous branch of the State Legislature.

2. No person shall be a Representative who shall not have attained to the age of twenty-five years and been seven years a citizen of the United States, and who shall not, when elected, be an inhabitant of that State in which he shall be chosen.

3. Representatives and direct taxes shall be apportioned among the several States which may be included within this Union according to their respective numbers, which shall be determined by adding to the whole number of free persons, including those bound to service for a term of years, and excluding Indians not taxed, three-fifths of all other persons. The actual enumeration shall be made within three years after the first meeting of the Congress of the United States, and within every subsequent term of ten years, in such manner as they shall by law direct. The number of Representatives shall not exceed one for every thirty thousand, but each State shall have at least one Representative; and until such enumeration shall be made, the State of New Hampshire shall be entitled to choose 3; Massachusetts, 8; Rhode Island and Providence Plantations, 1; Connecticut, 5; New York, 6; New Jersey 4; Pennsylvania, 8; Delaware, 1; Maryland, 6; Virginia, 10; North Carolina, 5; South Carolina, 5; and Georgia, 3.

4. When any vacancies happen in the representation from any State, the Executive Authority thereof shall issue writs of election to fill such vacancies.

5. The House of Representatives shall choose their Speaker and other officers, and shall have the sole power of impeachment.

Section 3.

1. The Senate of the United States shall be composed of two Senators from each State, chosen by the Legislature thereof, for six years; and each Senator shall have one vote.

2. Immediately after they shall be assembled in consequence of the first election, they shall be divided as equally as may be into three classes. The seats of the Senators of the first class shall be vacated at the expiration of the second year, of the second class at the expiration of the fourth year, and of the third class at the expiration of the sixth year; and if vacancies happen by resignation, or otherwise, during the recess of the Legislature of any State, the Executive thereof may make temporary appointment until the next meeting of the Legislature, which shall then fill such vacancies.

3. No person shall be a Senator who shall not have attained to the age of thirty years, and been nine years a citizen of the United States, and who shall not, when elected, be an inhabitant of that State for which he shall be chosen.

4. The Vice-President of the United States shall be President of the Senate, but shall have no vote unless they be equally divided.

5. The Senate shall choose their other officers, and also a President pro tempore, in the absence of the Vice-President, or when he shall exercise the office of President of the United States.

6. The Senate shall have the sole power to try all impeachments. When sitting for that purpose, they shall be on oath or affirmation. When the President of the United States is tried, the Chief Justice shall preside; and no person shall be convicted without the concurrence of two-thirds of the members present.

7. Judgment of cases of impeachment shall not extend further than to removal from office, and disqualification to hold and enjoy an office of honor, trust, or profit under the United States; but the party convicted shall nevertheless be liable and subject to indictment, trial, judgment, and punishment, according to law.

Section 4.

1. The times, places, and manner of holding elections for Senators and Representatives shall be prescribed in each State by the Legislature thereof; but the Congress may at any time by law make or alter such regulations, except as to places of choosing Senators.

2. The Congress shall assemble at least once in every year, and such meeting shall be on the first Monday in December, unless they shall by law appoint a different day.

Section 5.

1. Each House shall be the judge of the elections, returns, and qualifications of its own members, and a majority of each shall constitute a quorum to do business; but a small number may adjourn from day to day, and may be authorized to compel the attendance of absent members in such manner and under such penalties as each House may provide.

2. Each House may determine the rules of its proceedings, punish its members for disorderly behavior, and with the concurrence of two-thirds expel a member.

3. Each House shall keep a journal of its proceedings, and from time to time publish the same, excepting such parts as may in their judgment require secrecy; and the yeas and nays of the members of either House on any question shall, at the desire of one-fifth of those present, be entered on the journal.

4. Neither House, during the session of Congress shall, without the consent of the other, adjourn for more than three days, nor to any other place than that in which the two Houses shall be sitting.

Section 6.

1. The Senators and Representatives shall receive a compensation for their services to be ascertained by law, and paid out of the Treasury of the United States. They shall in all cases, except treason, felony, and breach of the peace, be privileged from arrest during their attendance at the session of the respective Houses, and in going to and returning from the same; and for any speech or debate in either House they shall not be questioned in any other place.

2. No Senator or Representative shall, during the time for which he was elected, be appointed to any civil office under the authority of the United States which shall have been created, or the emoluments whereof shall have been increased during such time; and no person holding any office under the United States shall be a member of either House during his continuance in office.

Section 7.

1. All bills for raising revenue shall originate in the House of Representatives, but the Senate may propose or concur with amendments, as on other bills.

2. Every bill which shall have passed the House of Representatives and the Senate shall, before it becomes a law, be presented to the President of the United States; if he approve, he shall sign it, but if not, he shall return it, with his objections, to that House in which it shall have originated, who shall enter the objections at large on their journal, and proceed to reconsider it. If after such reconsideration two-thirds of that House shall agree to pass the bill, it shall be sent, together with the objections,

to the other House, by which it shall likewise be reconsidered; and if approved by two-thirds of that House it shall become a law. But in all such cases the votes of both Houses shall be determined by yeas and nays, and the names of the persons voting for and against the bill shall be entered on the journal of each House respectively. If any bill shall not be returned by the President within ten days (Sundays excepted) after it shall have been presented to him, the same shall be a law in like manner as if he had signed it, unless the Congress by their adjournment prevent its return; in which case it shall not be a law.

3. Every order, resolution or vote to which the concurrence of the Senate and House of Representatives may be necessary (except on a question of adjournment) shall be presented to the President of the United States; and before the same shall take effect shall be approved by him, or being disapproved by him, shall be repassed by two-thirds of the Senate and the House of Representatives, according to the rules and limitations prescribed in the case of a bill.

Section 8.

1. The Congress shall have power: To lay and collect taxes, duties, imposts, and excises, to pay the debts and provide for the common defense and general welfare of the United States: but all duties, imposts, and excises shall be uniform throughout the United States;

2. To borrow money on the credit of the United States;

3. To regulate commerce with foreign nations, and among the several States, and with the Indian tribes;

4. To establish an uniform rule of naturalization and uniform laws on the subject of bankruptcies throughout the United States;

5. To coin money, regulate the value thereof, and of foreign coin, and fix the standards of weights and measures;

6. To provide for the punishment of counterfeiting the securities and current coin of the United States;

7. To establish post-offices and post-roads;

8. To promote the progress of science and useful arts by securing for limited times to authors and inventors the exclusive rights to their respective writings and discoveries;

9. To constitute tribunals inferior to the Supreme Court;

10. To define and punish piracies and felonies committed on the high seas, and offenses against the laws of nations;

11. To declare war, grant letters of marque and reprisal, and make rules concerning captures on land and water;

12. To raise and support armies, but no appropriation of money to that use shall be for a longer term that two years;

13. To provide and maintain a navy;

14. To make rules for the government and regulation of the land and naval forces;

15. To provide for calling forth the militia to execute the laws of the Union, suppress insurrections, and repel invasions;

16. To provide for organizing, arming, and disciplining the militia, and for governing such part of them as may be employed in the service of the United States, reserving to the States respectively the appointment of the officers, and the authority of training the militia according to the discipline prescribed by Congress;

17. To exercise exclusive legislation in all cases whatsoever over such district (not exceeding ten miles square) as may, by cession of particular States and the acceptance of Congress, become the seat of Government of the United States, and to exercise like authority over all places purchased by the consent of the Legislature of the State in which the same shall be, for the erection of forts, magazines, arsenals, dry-docks, and other needful buildings;

18. To make all laws which shall be necessary and proper for carrying into execution the foregoing powers and all other powers vested by this Constitution in the Government of the United States, or in any department or officer thereof.

Section 9.

1. The migration or importation of such persons as any of the states now existing shall think proper to admit shall not be prohibited by the Congress, prior to the year one thousand eight hundred and eight, but a tax or duty may be imposed on such importation, not exceeding ten dollars for each person.

2. The privilege of the writ of habeas corpus shall not be suspended, unless when in cases of rebellion or invasion the public safety may require it.

3. No bill of attainder or ex post facto law shall be passed.

4. No capitation or other direct tax shall be laid, unless in proportion to the census or enumeration hereinbefore directed to be taken.

5. No tax or duty shall be laid on articles exported from any State.

6. No preference shall be given by any regulation of commerce or revenue to the ports of one State over those of another, nor shall vessels bound to or from one State be obliged to enter, clear, or pay duties in another.

7. No money shall be drawn from the Treasury but in consequence of appropriations made by law; and a regular statement and account of the receipts and expenditures of all public money shall be published from time to time.

8. No title of nobility shall be granted by the United States. And no person holding any office of profit or trust under them shall, without the consent of the Congress, accept any present, emolument, office, or title, of any kind whatever, from any king, prince or foreign state.

Section 10.

1. No State shall enter into any treaty, alliance, or confederation, grant letters of marque and reprisal, coin money, emit bills of credit, make anything but gold and silver coin a tender in payment of debts, pass any bill of attainder, ex post facto law, or law impairing the obligation of contracts, or grant any title of nobility.

2. No State shall, without the consent of the Congress, lay any impost or duties on imports or exports, except what may be absolutely necessary for executing its inspection law, and the net produce of all duties and imposts, laid by any State on imports or exports, shall be for the use of the Treasury of the United States; and all such laws shall be subject to the revision and control of the Congress.

3. No State shall, without the consent of Congress, lay any duty of tonnage, keep troops or ships of war in time of peace, enter into agreement or compact with another State, or with a foreign power, or engage in war, unless actually invaded, or in such imminent danger as will not admit of delay.

ARTICLE II.

Section 1.

1. The Executive power shall be vested in a President of the United States of America. He shall hold his office during the term of four years, and, together with the Vice-President, chosen for the same term, be elected as follows:

2. Each State shall appoint, in such manner as the Legislature thereof may direct, a number of electors equal to the whole number of Senators and Representatives to which the State may be entitled in the Congress; but no Senator or Representative or person holding an office of trust or profit under the United States shall be appointed an elector.

3. The electors shall meet in their respective States and vote by ballot for two persons, of whom one at least shall not be an inhabitant of the same State with themselves. And they shall make a list of all the persons voted for, and of the number of votes for each, which list they shall sign and certify and transmit, sealed, to the seat of the Government of the United States, directed to the President of the Senate. The President of the Senate shall, in the presence of the Senate and House of Representatives, open all the certificates, and the votes shall then be counted. The person having the greatest number of votes shall be the President, if such number be a majority of the whole number of electors appointed, and if there be more than one who have such a majority, and have an equal number of votes, then the House of Representatives shall immediately choose by ballot one of them for President; and if no person have a majority, then from the five highest on the list the said House shall in like manner choose the President. But in choosing the President, the vote shall be taken by States, the representation from each State having one vote. A quorum, for this purpose, shall consist of a member or members from two-thirds of the States, and a majority of all the States shall be necessary to a choice. In every case, after the choice of the President, the person having the greatest number of votes of the electors shall be the Vice-President. But if there should remain two or more who have equal votes, the Senate shall choose from them by ballot the Vice-President.

4. The Congress may determine the time of choosing the electors and the day on which they shall give their votes, which day shall be the same throughout the United States.

5. No person except a natural born citizen, or a citizen of the United States, at the time of the adoption of this Constitution, shall be eligible to the office of President; neither shall any person be eligible to that office who shall not have attained to the age of thirty-five years and been fourteen years a resident within the United States.

6. In case of the removal of the President from office, or of his death, resignation, or inability to discharge the powers and duties of the said office, the same shall devolve on the Vice-President, and the Congress may by law provide for the case of removal, death, resignation, or inability, both of the President and Vice-President, declaring what officer shall then act as President, and such officer shall act accordingly, until the disability be removed or a President shall be elected.

7. The President shall, at stated times, receive for his services a compensation which shall neither be increased nor diminished during the period for

which he shall have been elected, and he shall not receive within that period any other emolument from the United States, or any of them.

8. Before he enters on the execution of his office he shall take the following oath or affirmation:

> I do solemnly swear (or affirm) that I will faithfully execute the office of President of the United States, and will, to the best of my ability, preserve, protect, and defend the Constitution of the United States.

Section 2.

1. The President shall be Commander-in-Chief of the Army and Navy of the United States, and of the militia of the several States when called into the actual service of the United States; he may require the opinion, in writing, of the principal officer in each of the executive departments upon any subject relating to the duties of their respective offices, and he shall have power to grant reprieves and pardons for offenses against the United States except in cases of impeachment.

2. He shall have power, by and with the advice and consent of the Senate, to make treaties, provided two-thirds of the Senators present concur, and he shall nominate and by and with the advice and consent of the Senate shall appoint ambassadors, other public ministers and consuls, judges of the Supreme Court, and all other officers of the United States whose appointments are not herein otherwise provided for, and which shall be established by law; but the Congress may by law vest the appointment of such inferior officers as they think proper in the President alone, in the courts of law, or in the heads of departments.

3. The President shall have power to fill up all vacancies that may happen during the recess of the Senate by granting commissions, which shall expire at the end of their next session.

Section 3.

He shall from time to time give to the Congress information on the state of the Union, and recommend to their consideration such measures as he shall judge necessary and expedient; he may, on extraordinary occasion, convene both Houses, or either of them, and in case of disagreement between them with respect to the time of adjournment, he may adjourn them to such time as he shall think proper; he shall receive ambassadors and other public ministers; he shall take care that the laws be faithfully executed, and shall commission all officers of the United States.

Section 4.

The President, Vice-President, and all civil officers of the United States shall be removed from office on impeachment for and conviction of treason, bribery or other high crimes and misdemeanors.

ARTICLE III.

Section 1.

The judicial power of the United States shall be vested in one Supreme Court, and in such inferior courts as the Congress may from time to time ordain and establish. The judges, both of the Supreme and inferior courts, shall hold their offices during good behavior, and shall at stated times receive for their services a compensation which shall not be diminished during their continuance in office.

Section 2.

1. The judicial power shall extend to all cases in law and equity arising under this Constitution, the laws of the United States, and treaties made, or which shall be made, under their authority; to all cases affecting ambassadors, other public ministers and consuls; to all cases of admiralty and maritime jurisdiction; to controversies to which the United States shall be a party; to controversies between two or more States, between a State and citizens of another State, between citizens of different States, between citizens of the same State claiming lands under grants of different States, and between a State, or the citizens thereof, and foreign states, citizens, or subjects.

2. In all cases affecting ambassadors, other public ministers, and consuls, and those in which a state shall be party, the Supreme Court shall have original jurisdiction. In all the other cases before mentioned the Supreme Court shall have appellate jurisdiction both as to law and fact, with such exceptions and under such regulations as the Congress shall make.

3. The trial of all crimes, except in cases of impeachment, shall be by jury, and such trial shall be held in the State where the said crimes shall have been committed; but when not committed within any State the trial shall be at such place or places as the Congress may be law have directed.

Section 3.

1. Treason against the United States shall consist only in levying war against them, or in adhering to their enemies, giving them aid and comfort. No person shall be convicted of treason unless on the testimony of two witnesses to the same overt act, or on confession in open court.

2. The Congress shall have power to declare the punishment of treason, but no attainder of treason shall work corruption of blood or forfeiture except during the life of the person attained.

ARTICLE IV.

Section 1.

Full faith and credit shall be given in each State to the public acts, records, and judicial proceedings of every other State. And the Congress may by general laws prescribe the manner in which such acts, records, and proceedings shall be proved, and the effect thereof.

Section 2.

1. The citizens of each state shall be entitled to all privileges and immunities of citizens in the several States.

2. A person charged in any State with treason, felony, or other crime, who shall flee from justice, and be found in another State, shall on demand of the Executive authority of the State from which he fled, be delivered up, to be removed to the State having jurisdiction of the crime.

3. No person held to service or labor in one State under the laws thereof, escaping into another shall in consequence of any law or regulation therein, be discharged from such service or labor, but shall be delivered upon claim of the party to whom such service or labor may be due.

Section 3.

1. New States may be admitted by the Congress into this Union; but no new State shall be formed or erected within the jurisdiction of any other State, nor any State be formed by the junction of two or more States, or parts of States, without the consent of the Legislatures of the States concerned, as well as of the Congress.

2. The Congress shall have the power to dispose of and make all needful rules and regulations respecting the territory or other property belonging to the United States; and nothing in this Constitution shall be so construed as to prejudice any claims of the United States, or of any particular State.

Section 4.

The United States shall guarantee to every State in this Union a Republican form of government, and shall protect each of them against invasion; and, on application of the Legislature, or of the Executive (when the Legislature cannot be convened), against domestic violence.

ARTICLE V.

The Congress, whenever two-thirds of both Houses shall deem it necessary, shall propose amendments to this Constitution, or, on the application of the Legislatures of two-thirds of the several States, shall call a convention for proposing amendments, which, in either case, shall be valid to all intents and purposes, as part of this Constitution, when ratified by the Legislature of three-fourths of the several States, or by conventions in three-fourths thereof, as the one or the other mode of ratification may be proposed by the Congress; provided that no amendment which may be made prior to the year one thousand eight hundred and eight shall in any manner affect the first and fourth clauses in the Ninth Section of the First Article; and that no State, without its consent, shall be deprived of its equal suffrage in the Senate.

ARTICLE VI.

1. All debts contracted and engagements entered into before the adoption of this Constitution shall be as valid against the United States under this Constitution as under the Confederation.

2. This Constitution and the laws of the United States which shall be made in pursuance thereof and all treaties made or which shall be made, under the authority of the United States, shall be the supreme law of the land, and the judges in every State shall be bound thereby, anything in the Constitution or law of any State to the contrary notwithstanding.

3. The Senators and Representatives before mentioned, and the members of the several State Legislatures, and all executive and judicial officers, both of the United States, and of the several States, shall be bound by oath or affirmation to support this Constitution, but no religious test shall ever be required as a qualification to any office or public trust under the United States.

ARTICLE VII.

The ratification of the Conventions of nine States shall be sufficient for the establishment of this Constitution between the States so ratifying the same.

THE TEN ORIGINAL AMENDMENTS (Effective 15 December 1791): CALLED *THE BILL OF RIGHTS*

AMENDMENT I.

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech or of the press; or the right of the people peaceably to assemble and to petition the Government for a redress of grievances.

AMENDMENT II.

A well-regulated militia being necessary to the security of a free State, the right of the people to keep and bear arms shall not be infringed.

AMENDMENT III.

No soldier shall, in time of peace, be quartered in any house without the consent of the owner, nor in time of war but in a manner to be prescribed by law.

AMENDMENT IV.

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

AMENDMENT V.

No person shall be held to answer for a capital or other infamous crime unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the militia, when in actual service, in time of war or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use without just compensation.

AMENDMENT VI.

In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the State and district wherein the crime shall have been committed, which districts shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the assistance of counsel for his defense.

AMENDMENT VII.

In suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any court of the United States than according to the rules of the common law.

AMENDMENT VIII.

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

AMENDMENT IX.

The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people.

AMENDMENT X.

The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

LATER AMENDMENTS

AMENDMENT XI.

The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States, by

citizens of another State, or by citizens or subjects of any foreign state.

AMENDMENT XII.

The Electors shall meet in their respective States, and vote by ballot for President and Vice-President, one of whom at least shall not be an inhabitant of the same State with themselves; they shall name in their ballots the person voted for as President, and in distinct ballots the person voted for as Vice-President; and they shall make distinct list of all persons voted for as President, and of all persons voted for as Vice-President, and of the number of votes for each, which list they shall sign and certify, and transmit, sealed, to the seat of the Government of the United States, directed to the President of the Senate; the President of the Senate shall, in the presence of the Senate and House of Representatives, open all the certificates and the votes shall then be counted; the person having the greatest number of votes for President shall be the President, if such number be a majority of the whole number of Electors appointed; and if no person have such majority, then from the persons having the highest number, not exceeding three, on the list of those voted for as President, the House of Representatives shall choose immediately, by ballot, the President. But in choosing the President, the votes shall be taken by States, the representation from each state having one vote; a quorum for this purpose shall consist of a member or members from two-thirds of the States, and a majority of all the States shall be necessary to a choice. And if the House of Representatives shall not choose a President, whenever the right of choice shall devolve upon them, before the fourth day of March next following, then the Vice-President shall act as President, as in the case of the death or other constitutional disability of the President. The person having the greatest number of votes as Vice-President shall be the Vice-President, if such number be a majority of the whole number of Electors appointed, and if no person have a majority, then from the two highest numbers on the list the Senate shall choose the Vice-President; a quorum for the purpose shall consist of two-thirds of the whole number of Senators, and a majority of the whole number shall be necessary to a choice. But no person constitutionally ineligible to the office of President shall be eligible to that of Vice-President of the United States.

AMENDMENT XIII.

1. Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States or any place subject to their jurisdiction.

2. Congress shall have power to enforce this article by appropriate legislation.

AMENDMENT XIV.

1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law, nor deny to any person within its jurisdiction the equal protection of the laws.

2. Representatives shall be apportioned among the several States according to their respective numbers counting the whole number of persons in each State excluding Indians not taxed. But when the right to vote at any election for the choice of Electors for President and Vice-President of the United States, Representatives in Congress, the executive and judicial officers of a State, or the members of the Legislature thereof, is denied to any of the male inhabitants of such State, being twenty-one years of age, and citizens of the United States, or in any way abridged, except for participation in rebellion, or other crime, the basis of representation therein shall be reduced in the proportion which the number of such male citizens shall bear to the whole number of male citizens twenty-one years of age in such States.

3. No person shall be a Senator or Representative in Congress, or Elector of President and Vice-President, or holding any office, civil or military, under the United States, or under any State, who, having previously taken an oath, as a member of Congress, or as an officer of the United States, or as a member of any State Legislature or as an executive or judicial officer of any State, to support the Constitution of the United States, shall have engaged in insurrection or rebellion against the same, or given aid and comfort to the enemies thereof. But Congress may, by a vote of two-thirds of each House, remove such disability.

4. The validity of the public debt of the United States, authorized by law, including debts incurred for payment of pensions and bounties for services in suppressing insurrection and rebellion, shall not be questioned. But neither the United States nor any State shall assume or pay any debt or obligation incurred in aid of insurrection or rebellion against the United States, or any claim for the loss or emancipation of any slave; but all such debts, obligations, and claims shall be held illegal and void.

5. The Congress shall have power to enforce by appropriate legislation the provision of this article.

AMENDMENT XV.

1. The right of the citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of race, color, or previous condition of servitude.

2. The Congress shall have power to enforce the provisions of this article by appropriate legislation.

AMENDMENT XVI.

The Congress shall have power to lay and collect taxes on incomes, from whatever sources derived, with apportionment among the several States and without regard to any census or enumeration.

AMENDMENT XVII.

1. The Senate of the United States shall be composed of two Senators from each State, elected by the people thereof, for six years; and each Senator shall have one vote. The electors in each State shall have the qualifications requisite for electors of the most numerous branch of the State Legislatures.

2. When vacancies happen in the representation of any State in the Senate, the executive authority of such State shall issue writs of election to fill such vacancies: Provided, That the Legislature of any State may empower the Executive thereof to make temporary appointment until the people fill the vacancies by election as the Legislature may direct.

3. This amendment shall not be so construed as to affect the election or term of any Senator chosen before it becomes valid as part of the Constitution.

AMENDMENT XVIII.

1. After one year from the ratification of this article the manufacture, sale, or transportation of intoxicating liquors within, the importation thereof into, or the exportation thereof from the United States and all territory subject to the jurisdiction thereof for beverage purposes is hereby prohibited.

2. The Congress and the several States shall have concurrent power to enforce this article by appropriate legislation.

3. This article shall be inoperative unless it shall have been ratified as an amendment to the Constitution by the Legislatures of the several States, as provided in the Constitution, within seven years from the date of the submission hereof to the States by the Congress.

AMENDMENT XIX.

1. The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of sex.

2. Congress shall have power, by appropriate legislation, to enforce the provisions of this article.

AMENDMENT XX.

1. The terms of the President and Vice-President shall end at noon on the 20th day of January, and the terms of the Senators and Representatives at noon on the 3rd day of January, of the years in which such terms would have ended if this article had not been ratified; and the terms of their successors shall then begin.

2. The Congress shall assemble at least once in every year, and such meeting shall begin at noon on the 3rd day of January, unless they shall by law appoint a different day.

3. If, at the time fixed for the beginning of the term of the President, the President elect shall have died the Vice-President shall become President. If a President shall not have been chosen before the time fixed for the beginning of his term, or if the President elect shall have failed to qualify, then the Vice-President elect shall act as President until a President shall have qualified; and the Congress may by law provide for the case wherein neither a President elect nor a Vice-President elect shall have qualified, declaring who shall then act as President, or the manner in which one who is to act shall be selected, and such person shall act accordingly until a President or Vice-President shall have qualified.

4. The Congress may by law provide for the case of the death of any of the persons from whom the House of Representatives may choose a President whenever the right of choice shall have devolved upon them, and for the case of the death of any of the persons from whom the Senate may choose a Vice-President whenever the right of choice shall have devolved upon them.

5. Sections 1 and 2 shall take effect on the 15th day of October following the ratification of this article.

6 This article shall be inoperative unless it shall have been ratified as an amendment to the Constitution by the Legislatures of three-fourths of the several States within seven years from the date of its submission.

AMENDMENT XXI.

1. The eighteenth article of amendment to the Constitution is hereby repealed.

2. The transportation or importation into any State, Territory, or Possession of the United States for delivery or use therein of intoxicating liquors, in violation of the laws thereof, is hereby prohibited.

3. This article shall in inoperative unless it shall have been ratified as an amendment to the Constitution by conventions in the several States, as provided in the Constitution, within seven years from the date of the submission hereof to the States by the Congress.

AMENDMENT XXII.

1. No person shall be elected to the office of the President more than twice, and no person who has held the office of President, or acted as President, for more than two years of a term to which some other person was elected President shall be elected to the office of the President more than once. But this Article shall not apply to any person holding the office of President when this Article was proposed by the Congress, and shall not prevent any person who may be holding the office of President, or acting as President, during the term within which this Article becomes operative from holding the office of President or acting as President during the remainder of such term.

2. This Article shall be inoperative unless it shall have been ratified by an amendment to the Constitution by the Legislature of three-fourths of the several States within seven years from the date of its submission to the States by the Congress.

AMENDMENT XXIII.

1. The District constituting the seat of Government of the United States shall appoint in such manner as the Congress may direct.

2. A number of electors of President and Vice-President equal to the whole number of Senators and Representatives in Congress to which the District would be entitled if it were a State, but in no event more than the least populous State; they shall be in addition to those appointed by the States, but they shall be considered, for the purposes of the election of President and Vice-President, to be electors appointed by a State; and they shall meet in the District and perform such duties as provided by the twelfth article of amendment.

AMENDMENT XXIV.

1. The right of citizens of the United States to vote in any primary or other election for President or Vice-President, for electors for President or Vice-President, or for senator or representative in Congress, shall not be denied or abridged by the United States or any state by reason of failure to pay any poll tax or other tax.

2. The Congress shall have the power to enforce this article by appropriate legislation.

AMENDMENT XXV.

1. In case of the removal of the President from office or his death or resignation, the Vice-President shall become President.

2. Whenever there is a vacancy in the office of the Vice-President, the President shall nominate a Vice-President who shall take office upon confirmation by a majority vote of both houses of Congress.

3. Whenever the President transmits to the president pro tempore of the Senate and the speaker of the House of Representatives his written declaration that he is unable to discharge the powers and duties of his office, and until he transmits to them a written declaration to the contrary, such powers and duties shall be discharged by the Vice-President as Acting President.

4. Whenever the Vice-President and a majority of either the principal officers of the executive departments or of such other body as Congress may be law provide, transmit to the president pro tempore of the Senate and the speaker of the House of Representatives their written declaration that the President is unable to discharge the powers and duties of his office the Vice-President shall immediately assume the powers and duties of the office as Acting President. Thereafter, when the President transmits to the president pro tempore of the Senate and the speaker of the House of Representatives his written declaration that no inability exists, he shall resume the powers and duties of his office unless the Vice-President and a majority of either the principle officers of the executive departments or of such other body as Congress may by law provide, transmit within four days to the president pro tempore of the Senate and the speaker of the House of Representatives their written declaration that the President is unable to discharge the powers an duties of his office. There upon Congress shall decide the issue, assembling within forty-eight hours for that purpose if not is session. If the Congress, within twenty-one days after receipt of the latter written declaration, or, if Congress is not is session, within twenty-one days after Congress is required to assemble, determines by two-thirds vote of both houses that the President is unable to discharge the powers and duties of his office the Vice-President shall continue to discharge the same as Acting President; otherwise, the President shall resume the powers and duties of his office.

AMENDMENT XXVI.

1. The right of citizens of the United States, who are eighteen years of age or older, to vote shall not be denied or abridged by the United States or by any State on account of age.

2. The Congress shall have power to enforce this article by appropriate legislation.

AMENDMENT XXVII.

No law, varying the compensation for the services of the Senators and Representatives, shall take effect, until an election of Representatives shall have intervened.[1]

[1] Proposed September 25, 1789; approved July 2, 1992.

APPENDIX B

VOCABULARY OF MEDICAL ETHICS

VOCABULARY OF MEDICAL ETHICS
(A SHORT LIST OF TERMS)

BIOETHICS -- that branch of ethics dealing with medicine and the life sciences; the application of normative ethics to the life sciences, including medicine and associated research.

CLINICAL ETHICS -- that segment of bioethics which is typically restricted to the recognition and resolution of ethical problems involved in the care of a single patient but which is actually broader in scope, encompassing the more general application of medical ethics through policy.

DESCRIPTIVE ETHICS – that division of nonnormative ethics that investigates what people believe and how they act with regard to ethics.

ETHICS -- the branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions. --*Random House Collegiate Dictionary*

METAETHICS – that division of nonnormative ethics that investigates and analyzes language and reasoning in ethics.

NON-NORMATIVE ETHICS – the study of what *is, not what ought to be* the case, ethically; this discipline is further divided into *descriptive ethics* and *metaethics.*

NORMATIVE ETHICS -- the study that attempts to answer the question, "What ought to be the case?"

ORGANIZATIONAL ETHICS -- that segment of bioethics which involves the structures and processes by which an organization attempts to ensure conduct appropriate to its values, mission, and vision.

ALSO----

ADVANCE DIRECTIVE -- a document by which a competent individual provides for the making of medical decisions during periods of his/her incompetence; generally a living will or a durable power-of-attorney for medical care, although some definitions would include a do-not-resuscitate order if requested by the patient

DIRECTIVE TO PHYSICIANS – See LIVING WILL.

DURABLE POWER-OF-ATTORNEY FOR MEDICAL CARE -- a type of advance medical directive authorized by statute in many states; a document that enables a

competent adult to retain control over his/her own medical care during periods of incapacity through prior designation of an individual to make health care decisions on his or her behalf.

EXTRAORDINARY MEANS -- a bioethical term, originally from Catholic moral theology, generally encompassing those drugs, devices, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience or which, if used, would offer no reasonable hope of benefit.

FUTILITY -- "serving no useful purpose; completely ineffective" according to Webster's Ninth New Collegiate Dictionary. But, there is today, much discussion about the meaning of futility in medical ethics. Do we ever know when something is hopeless? What about for those who believe in miracles? What if we were to say, "to a medical certainty, it will have no good effect"? Good effect for whom? Must we always address only the original patient? What if it has no effect on the original patient but has a good effect on the patient's family members? This is truly a value laden term.

LIVING WILL -- a type of advance medical directive authorized by statute in most states; in general, a document executed by an individual, while competent, directing health care providers to use, or not to use, or to withdraw certain life-sustaining modalities from him or her should he or she become incompetent and be in a terminal condition.; sometimes called a Directive to Physicians.

ORDINARY MEANS -- a bioethical term, originally from Catholic moral theology, encompassing drugs, devices, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience.

PRIMA FACIE - -Latin: 'at first sight'; apparent.

PRINCIPLE OF AUTONOMY (Respect for Autonomy) -- the ethical principle which requires that each person be permitted self-governance, i.e., the determination of his own action in accordance with his own plan.

PRINCIPLE OF BENEFICENCE -- the ethical principle which requires one to do good.

PRINCIPLE OF JUSTICE -- the ethical principle which requires one to give to each his just desserts.

PRINCIPLE OF NONMALEFICENCE -- the ethical principle which requires that one not harm another; the principle of nonmaleficence is exemplified by the ancient medical maxim *primum non nocere* –"first, or above all, do no harm."

PRINCIPLE OF RESPECT FOR PERSONS -- a recent statement of ethical principle which incorporates the principle of autonomy and certain aspects of the principles

of beneficence and nonmaleficence, specifically requiring that society protect non-autonomous persons.

PRINCIPLE OF UTILITY -- the ethical principle which requires one to act so as to bring about the greatest benefit and the least harm; the basis of utilitarianism; not accepted as valid by pure deontologists.

RULE OF DOUBLE EFFECT -- permits one to effect a harm, provided that the harm is an indirect, unintended, or unforeseen effect of an action and is not the direct and intended effect of the action.

TERMINAL CONDITION -- a medical condition which physicians believe is likely to result in death within a short period of time, even with medical intervention.

APPENDIX C

CASES ARRANGED CHRONOLOGICALLY

CASES IN CHRONOLOGICAL ORDER

APPENDIX D

CASES GROUPED BY SUBJECT

These grouping are provided only as suggestions for discussion. You may disagree with them; you may certainly change them. For example, many people might include the cases that I have listed under the *Right to Refuse Care* under the *Right to Die*. The possibilities for groupings are extensive.

CASES GROUPED CHRONOLOGICALLY WITHIN SUBJECT AREAS

Miscellaneous

Physician-Assisted Suicide

Right to Die

Right to Privacy

Right to Refuse Care

APPENDIX E

TABLE OF CASES

Cases listed in the Table of Contents, the primary cases, are shown in this Table of Cases in **bold** print. The number of the page on which such a case begins is underlined. All other cases, i.e., those not in bold print, are those cited *within* the primary cases.

H

J

K

L

Q

R

S

Y

Z

APPENDIX F

ABOUT THE EDITORS

KARIN WAUGH ZUCKER is an Associate Professor of Health Care Administration, Baylor University and the Consultant in Bioethics to Brooke Army Medical Center. She teaches, or has taught, health care law, managed care law, health care contracting, health politics and policy, negotiations, international health, human resources management, and ethics –introduction to medical ethics, clinical ethics, organizational ethics, and the law and ethics of war and terrorism. Professor Zucker received her B.A. in political science from Quincy College in Quincy, Illinois; her M.A. in philosophy from Boston College in Chestnut Hill, Massachusetts; her J.D. from the University of Missouri at Kansas City, Missouri; and her M.F.S. and LL.M. from George Washington University, Washington, D.C. Among her assignments while on active duty with the Judge Advocate General's Corps, U.S. Army, were tours as the Command Judge Advocate for the U.S. Army Medical Command Europe (7th Medical Command) and as the Legal Counsel for the Armed Forces Institute of Pathology and the Collaborative Center for the Investigation of AIDS. While in the Army, she also held academic appointments at the University of Maryland, the University of Texas Health Science Center – Houston, Texas Wesleyan University, and Tulane University. She is now a Department of the Army civilian employee with the Army – Baylor University Graduate Program in Health and Business Administration at the Army Medical Department Center and School. Professor Zucker is a member of the American College of Legal Medicine, the American Society of Law, Medicine, and Ethics, the American Bar Association, and the Association of Professional and Practical Ethics. She has lectured widely in the United States and abroad on legal medicine and bioethics and has chaired numerous seminars on related topics.

TRACY L. ALLEN is a captain in the U.S. Air Force Medical Service Corps and has been selected for promotion to major. She is currently serving as TRICARE Operations and Patient Administration Flight Commander at the 579th Medical Group, Bolling Air Force Base, Washington D.C. Her prior assignments include a tour as Chief, Expeditionary Medical Operations at Headquarters, Air Education and Training Command, Directorate of the Surgeon General, Randolph Air Force Base, Texas; Personnel and Administration Flight Commander and Executive Officer at the 18th Medical Group, Okinawa, Japan; and Medical Readiness Flight Commander at the 18th Medical Group, Okinawa, Japan. Capt Allen deployed in support of Operation Northern Watch, serving as Chief of Protocol to the Joint Task Force commander. She received her M.H.A. from Baylor University (Army - Baylor Program) and her MBA Degree from the University of Texas at San Antonio in 2004. Tracy is a Diplomate of the American College of Healthcare Executives.

MARTIN JAMES BOYLE is a Senior Attorney with the Office of the General Counsel, Department of Veterans Affairs. His principal areas of practice are medical malpractice litigation, hospital operations and administration, and medical research. He is a member of the VA General Counsel team that handles the legal affairs of the 90 VA medical research foundations. Mr. Boyle received his B.A. in philosophy from Marquette University in Milwaukee, Wisconsin, and his J.D. from St. Mary's University in San Antonio, Texas. While on active duty with the Judge Advocate General's Corps, U.S. Army, he served as the Command Judge Advocate for Letterman Army Medical Center, as a Staff Attorney for the U.S. Army Claims Service, and as the Medical Claims Judge Advocate and the first Risk Manager for Walter Reed Army Medical Center. For many years Mr. Boyle lectured once a semester at the Baylor Medical School in Houston, Texas; he is now a frequent guest lecturer for the Army-Baylor University Graduate Program in Health and Business Administration, and he Army – Baylor Short Course in Medical Ethics. He has also lectured extensively in the civilian, medical community on medico-legal matters, particularly quality assurance, risk management, and privileging.

AMY BURTON has been deployed. Her biography will be included when received.

VITO S. SMYTH is a major in the U.S. Air Force Medical Service Corps currently serving as a Duty Watch Officer with the Air Force Medical Operations Center, Air Force Medical Operations Agency, Office of the Air Force Surgeon General, Washington, D.C. In this capacity, he serves on a staff that provides oversight of all aspects of Air Force Medical Service expeditionary operations and provides advice and counsel to senior Air Force Medical Service leadership. Among his previous assignments were Executive Officer to the Command Surgeon and Assistant Surgeon General for Dental Services, Headquarters Air Force Materiel Command, Wright-Patterson AFB, Ohio; and Internal Medicine Flight Group Practice Manager, 88th Medical Group, Wright-Patterson Air Force Base, Ohio. As an Air Force Institute of Technology student, he completed an administrative residency with the Greater San Antonio Hospital Council, San Antonio, Texas, focusing on advocate-ing healthcare issues and solutions to various governmental agencies. Major Smyth deployed in support of Operation Noble Eagle as a Medical Operations Planner with Joint Task Force Civil Support, United States Northern Command, Fort Monroe, Virginia. Major Smyth received his B.S. in Business and Management from the University of Maryland in 1993, his J.D. Cleveland State University Cleveland-Marshall College of Law in 1996, and his M.H.A from Baylor University (Army - Baylor Program) in 2004. He is a Fellow of the American College of Healthcare Administrators. Major Smyth, who still actively practices law, became a licensed attorney in Ohio in 1996. He is also admitted to the bar of the Supreme Court of the United States, the U.S. Court of Appeals for the Sixth Circuit, and the U.S. Court of Appeals for the Armed Forces.

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Abstract

The ethics of a people, as demonstrated through public policy, are generally thought to inform that people's legal system and its decisions. The converse is also true: decisions within a legal system inform, or impact, ethics –specifically medical ethics. The cases discussed in this paper are at the foundation of medical ethics in the United States. They address informed consent, abortion, refusal of medical care, the right to die, surrogate motherhood, and medical research, among other topics. Cases unique to the military are also included.

This monograph includes significant excerpts from 25 cases. The excerpts include those portions of the decisions that address the most important ethical issues. Appendices include the United States Constitution, the vocabulary of medical ethics, a chronological list of cases, cases grouped by subject, a table of all cited cases, and biographies of the editors.