

# Physician Liability for Failure to Resuscitate Terminally Ill Patients

## I. INTRODUCTION

Modern medical technology has made tremendous strides over the last few decades. Medical science is now capable of sustaining organic life in situations where death would certainly occur without application of available technology.<sup>1</sup> Although these advances have saved many lives, they have also created awesome problems for the physicians and other health care professionals attending the terminally ill, hospitalized patient.<sup>2</sup> In treating the terminally ill, the physician may have an extensive spectrum of treatment options available, treatment offering no hope of a cure, but only serving to prolong the dying process.<sup>3</sup> Thus, the physician is forced to choose among treatments that are not therapeutic, but which will affect the time and mode of dying.<sup>4</sup>

The changing definition of death over the past decade further complicates the physician's dilemma. For centuries a heartbeat and respirations distinguished life from death.<sup>5</sup> Today, however, the trend is toward redefining death as the irreversible loss of brain function.<sup>6</sup> The issues of "brain death," "the right to die," and "who pulls the plug" had generated controversy in both the medical and legal professions before *In re Quinlan*.<sup>7</sup> That decision, however, triggered a re-examination of the concept of death. In addition, it raised questions concerning the responsibilities of physicians in caring for the competent dying patient, and the patient who is incompetent be-

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<sup>1</sup>Teel, *The Physician's Dilemma—A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 6 (1975).

<sup>2</sup>While exact figures are not available, it is estimated that 80% of all deaths in the United States occur in hospitals or nursing homes. Annas, *Rights of the Terminally Ill Patient*, 1974 J. NURSING AD. 40, 40 (Mar.-Apr. 1974). There is no precise medical or legal definition of a terminal disease. In common usage, such a condition is one without cure and which will result in death, whether life-prolonging therapy is administered or not. Note, *No-Code Orders vs. Resuscitation: The Decision to Withhold Life-Prolonging Treatment from the Terminally Ill*, 26 WAYNE L. REV. 139, 140 n.6 (1979).

<sup>3</sup>Morison, *Dying*, 229 SCIENTIFIC AM. 55, 55 (Sept. 1973).

<sup>4</sup>Grenvik, Powner, Snyder, Jatremski, Babcock & Loughhead, *Cessation of Therapy in Terminal Illness and Brain Death*, 6 CRITICAL CARE MED. 284, 284 (1978).

<sup>5</sup>BLACK'S LAW DICTIONARY 488 (4th ed. 1968). See also *Smith v. Smith*, 229 Ark. 579, 317 S.W.2d 275 (1958); *Thomas v. Anderson*, 96 Cal. App. 2d 371, 215 P.2d 478 (1950); *Schmitt v. Pierce*, 344 S.W.2d 120 (Mo. 1961).

<sup>6</sup>See Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J. A.M.A. 337 (1968).

<sup>7</sup>See 137 N.J. Super. 227, 348 A.2d 801 (Ch. Div. 1975), *rev'd*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

cause of coma, medication, mental retardation, etc., and therefore incapable of expressing his wishes concerning his medical care.

Although our society permits a competent terminally ill patient to refuse life-saving or life-prolonging treatment,<sup>8</sup> our system of law generally does not authorize one person to make life and death decisions for another.<sup>9</sup> Yet, the physician who treats an incompetent terminally ill patient must constantly evaluate whether "continued maximal efforts constitute a reasonable attempt at prolonging life, or whether the patient's illness has reached a stage where further intensive care is, in fact, merely postponing death."<sup>10</sup> This dilemma is present and must be addressed when a physician decides whether to administer cardiopulmonary resuscitation to such a patient.

This Note will explore when the decision to withhold cardiopulmonary resuscitation (CPR)<sup>11</sup> from competent and incompetent terminally ill patients is legally permissible. In making this determination, this Note will focus on the various factors that must be considered, including when CPR is extraordinary treatment and how the decision may be affected by the brain death definition of death.

## II. CHANGING DEFINITIONS OF DEATH

### A. *Traditional Definition of Death*

Until recently, death was considered a simple occurrence, "defined by physicians as the total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc."<sup>12</sup> The courts fully accepted this definition of death,<sup>13</sup> and indeed had no choice, because physicians were incapable of re-establishing the function of the heart and lungs after activity ceased.<sup>14</sup> While the moment of death has legal significance in various types of cases including homicide, taxation, inheritance, pro-

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<sup>8</sup>Ufford, *Brain Death/Termination of Heroic Efforts to Save Life—Who Decides?*, 19 WASHBURN L.J. 225, 225 (1980).

<sup>9</sup>Note, *supra* note 2, at 140.

<sup>10</sup>Clinical Care Committee of the Massachusetts General Hospital, *Optimum Care for Hopelessly Ill Patients*, 295 NEW ENG. J. MED. 362, 362 (1976).

<sup>11</sup>See notes 41-56 *infra* and accompanying text.

<sup>12</sup>BLACK'S LAW DICTIONARY 488 (4th ed. 1968).

<sup>13</sup>See *Smith v. Smith*, 229 Ark. 579, 317 S.W.2d 275 (1958); *Estate of Schmidt*, 261 Cal. App. 2d 262, 67 Cal. Rptr. 847 (1968); *Sauers v. Stolz*, 121 Colo. 456, 218 P.2d 741 (1950); *In re Davenport's Estates*, 79 Idaho 548, 323 P.2d 611 (1958); *Prudential Ins. Co. v. Spain*, 339 Ill. App. 476, 90 N.E.2d 256 (1950); *United Trust Co. v. Ryke*, 199 Kan. 1, 427 P.2d 67 (1967); *Gray v. Sawyer*, 247 S.W.2d 496 (Ky. 1952); *Vaegemast v. Hess*, 203 Minn. 207, 280 N.W. 641 (1938); *Finch v. Edwards*, 239 Mo. App. 788, 198 S.W.2d 665 (1946); *Evans v. New York*, 49 N.Y. 86 (1872); *Evans v. Halterman*, 31 Ohio App. 175, 165 N.E. 869 (1928); *Glover v. Davis*, 366 S.W.2d 227 (Tex. 1963).

<sup>14</sup>See *Corday, Life-Death in Human Transplantation*, 55 A.B.A. J. 629, 630 (1969).

perty rights, insurance claims, wrongful death, and transplantation,<sup>15</sup> the law does not ordinarily attempt to define death.<sup>16</sup> Generally, the courts rely upon the expert testimony of physicians to determine the fact and time of death.<sup>17</sup>

Until recently, the few modern court decisions involving a definition of death used the concept of the total cessation of all vital signs.<sup>18</sup> In doing so, the courts made the assumption that the medical criteria for determining death were settled and agreed upon by physicians.<sup>19</sup> In *Thomas v. Anderson*,<sup>20</sup> decided in 1950, the California Court of Appeals held that "death occurs precisely when life ceases and does not occur until the heart stops beating and respirations end. Death is not a continuous event and is an event that takes place at a precise time."<sup>21</sup>

Unfortunately, this traditional definition of death has the potential for ludicrous results. In *Gray v. Sawyer*,<sup>22</sup> a husband and wife were killed by a train at a railroad crossing. The husband's body was horribly mutilated and the wife was decapitated, but a witness to the accident observed blood spurting from the neck of the wife's body.<sup>23</sup> In an action to determine survivorship, doctors applying the traditional definition of death testified that "a body is not dead so long as there is a heartbeat, and that may be evidenced by the gushing of blood in spurts."<sup>24</sup>

Another problem with the traditional definition of death is that technological advances have outmoded it.<sup>25</sup> Cardiopulmonary resuscitation is capable of returning to life individuals who fulfill the traditional criteria for death.<sup>26</sup> Respirators, dialysis equipment,

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<sup>15</sup>Ufford, *supra* note 8, at 227.

<sup>16</sup>Corday, *supra* note 14, at 630.

<sup>17</sup>*Id.*

<sup>18</sup>See Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *supra* note 6, at 338.

<sup>19</sup>See *id.*

<sup>20</sup>96 Cal. App. 2d. 371, 215 P.2d 478 (1950).

<sup>21</sup>*Id.* at 376, 215 P.2d at 482.

<sup>22</sup>247 S.W.2d 496 (Ky. 1952).

<sup>23</sup>*Id.* at 497.

<sup>24</sup>*Id.* The appellate court upheld the trial court's decision that the couple died simultaneously because the witness' testimony was not presented in the trial court. Without that testimony there was no evidence as to which individual died first; therefore, the deaths were held to be simultaneous. *Id.* at 498. It is likely the court would have ruled otherwise had the witness' testimony been available.

<sup>25</sup>Ufford, *supra* note 8, at 226.

<sup>26</sup>Beecher, *Ethical Problems Created by the Hopelessly Ill Patient*, 278 NEW ENG. J. MED. 1425, 1426 (1968). See Beck, Weckesser & Barry, *Fatal Heart Attack and Successful Defibrillation*, 161 J. A.M.A. 434 (1956). This was the first published case of a successful resuscitation outside an operating room. Today, cardiopulmonary resuscitation is commonplace.

pacemakers, and organ transplantation are capable of prolonging lives which previously would have ended much earlier.<sup>27</sup>

### B. Modern Concept of Death

Technological advances resulting in indefinite prolongation of life in the traditional sense, that is, the presence of cardiac and respiratory functions, have prompted the medical profession to develop a definition of human death that includes brain death as a criterion.<sup>28</sup> Brain death generally describes permanent cessation of all brain functions.<sup>29</sup> Because the brain and its stem control vital activities such as heartbeat and respiration, cessation of these vital somatic functions invariably follows cessation of brain function unless cardiac and respiratory functions are supported mechanically.<sup>30</sup> Brain death is distinct from chronic vegetative states, wherein the individual has lost the cognitive qualities of self-awareness and the ability to communicate and interact with others, but certain vital functions such as respiration, temperature, and blood pressure are retained because the brain stem is intact.<sup>31</sup> Such individuals are brain damaged, but they are not brain dead.

In 1968, the Ad Hoc Committee of the Harvard Medical School set forth clinical criteria to establish brain death.<sup>32</sup> A person who is brain dead is in a deep coma marked by unresponsiveness to painful, externally applied stimuli, lack of spontaneous movement and respiration, and lack of reflexes, including blink, light, cough and tendon reflexes.<sup>33</sup> While various organizations, medical schools, and

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<sup>27</sup>Ufford, *supra* note 8, at 226.

<sup>28</sup>See Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *supra* note 6.

<sup>29</sup>Irreversible coma can have various causes including cardiac arrest, asphyxia with respiratory arrest, massive brain damage secondary to trauma, and both neoplastic and vascular intracranial lesions. *Id.* at 339.

<sup>30</sup>National Institute of Neurological and Communicative Disorders and Stroke, *An Appraisal of the Criteria of Cerebral Death: A Summary Statement*, 237 J. A.M.A. 982, 984 (1977).

<sup>31</sup>Such was the condition of Karen Ann Quinlan. See *In re Quinlan*, 70 N.J. 10, 24, 355 A.2d 647, 654, *cert. denied*, 429 U.S. 922 (1976).

<sup>32</sup>Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *supra* note 6.

<sup>33</sup>*Id.* at 337-38. The Harvard Criteria denote a flat or isoelectric electroencephalogram (EEG) to be of great confirmatory value, but other medical experts caution against placing too much emphasis on EEG readings alone. One year following the Harvard Report, the Ad Hoc Committee of the American Electroencephalographic Society on EEG Criteria for the Determination of Cerebral Death urged refinement in the use of the EEG in determining death. The Committee was adamant in stating that the EEG should never be used alone to diagnose cerebral death. Ad Hoc Committee of the American Electroencephalographic Society on EEG Criteria for the Determination

hospitals have established their own "brain death guidelines" or protocols, they have incorporated the Harvard Criteria into those guidelines, with refinements.<sup>34</sup>

The virtually universal acceptance of the brain death standard by the medical profession<sup>35</sup> has resulted in concomitant developments in the law. Thirty states, either by statute<sup>36</sup> or judicial decision,<sup>37</sup> have adopted brain death definitions to supplement the traditional standards of death determination. While Arkansas, Montana, and Tennessee articulate only the brain death standard in their definition of death statutes,<sup>38</sup> all the other states adopting the brain death standard have expressly retained the traditional criteria

of Cerebral Death, *EEG Criteria for the Determination of Cerebral Death*, 209 J. A.M.A. 1505 (1969). Still other medical experts maintain that while helpful, the EEG is neither "necessary nor sufficient in diagnosing brain death." *Lovato v. District Ct.*, 198 Colo. 419, 601 P.2d 1072, 1078 (1979) (quoting the Report of the Ad Hoc Brain Death Committee of the Colorado Association of Clinical Neurologists (Nov. 1978)).

<sup>34</sup>See Ufford, *supra* note 8, at 229. Any brain death protocol should be clear and distinct, contain tests which are relatively simple to perform and interpret, contain multiple criteria which are not rigid, be compatible with traditional criteria of death, and recognize that the primary diagnosis of brain death is clinical. *Id.*

<sup>35</sup>See Black, *Brain Death, Part I & Part II*, 299 N. ENG. J. MED. 338, 393 (1978); Conway, *Medical and Legal Views of Death: Confrontation and Reconciliation*, 19 ST. LOUIS U.L.J. 172 (1974); National Institute of Neurological and Communicative Disorders and Stroke, *An Appraisal of the Criteria of Cerebral Death: A Summary Statement*, 237 J. A.M.A. 982 (1977); Podgers, *Brain Death Concept Gaining Acceptance*, 66 A.B.A. J. 272 (1980).

<sup>36</sup>1979 Ala. Acts 165; ALASKA STAT. § 09.65.120 (1980); ARK. STAT. ANN. § 82-537 (Supp. 1979); CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1981); 1979 Conn. Pub. Acts 79-556; GA. CODE § 88-1715.1 (1975); HAWAII REV. STAT. § 327C-1 (Supp. 1980); IDAHO CODE § 54-1819 (Supp. 1981); ILL. REV. STAT. ch. 110½, § 302 (1979); IOWA CODE § 702.8 (1979); KAN. STAT. ANN. § 77-202 (Supp. 1979); LA. CIV. CODE ANN. art. 9:111 (West Supp. 1981); MD. ANN. CODE art. 43, § 54-F (1980); MICH. COMP. LAWS § 333.1021 (1980); MONT. REV. CODES ANN. § 69-7201 (Supp. 1977); 1979 Nev. Stats. 162; N.M. STAT. ANN. § 12-2-4 (1978); N.C. GEN. STAT. § 90-332 (Supp. 1977); OKLA. STAT. tit. 63, § 1-301 (Supp. 1980); OR. REV. STAT. § 146.001 (1979); TENN. CODE ANN. § 53-459 (1977); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1980); VA. CODE § 54-325.7 (Supp. 1981); W. VA. CODE § 16-19-1 (1979); WYO. STAT. § 35-19-101 (1977).

<sup>37</sup>*State v. Fierro*, 124 Ariz. 182, 603 P.2d 74 (1979); *Lovato v. District Ct.*, 198 Colo. 1419, 601 P.2d 1072 (1979); *Swafford v. State*, 421 N.E.2d 596 (Ind. 1981); *Commonwealth v. Golston*, 373 Mass. 249, 36 N.E.2d 744 (1977), *cert. denied*, 434 U.S. 1039 (1978); *In re Bowman*, 94 Wash. 2d 407, 617 P.2d 731 (1980).

<sup>38</sup>ARK. STAT. ANN. § 82-537 (Supp. 1981); TENN. CODE ANN. § 53-459 (1977); MONT. REV. CODES ANN. § 69-7201 (Supp. 1977). For example, the Montana statute, section 69-7201, reads as follows: "A human body with irreversible cessation of total brain function, as determined according to usual and customary standards of medical practice, is dead for all legal purposes." But, the recommendation of the National Conference of Commissioners on Uniform State Laws is that "[a]n individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem is dead. A determination of death must be made in accordance with accepted medical

for death. None of the states and advisory committees which have adopted brain death definitions have specified any criteria for brain death determination;<sup>39</sup> they have reserved this task for the medical profession.<sup>40</sup>

### III. CARDIOPULMONARY RESUSCITATION

Cardiopulmonary resuscitation (CPR) is one of the technological advances in modern medical practice which has helped to erode the validity of the traditional criteria of death.<sup>41</sup> Until the 1950's, cardiac arrest was synonymous with death. At that time, Claude Beck startled the medical profession with demonstrations showing that many nonfunctioning hearts sustain only small amounts of damage and can be revived following cardiac arrest.<sup>42</sup> Today CPR encompasses numerous medical procedures when performed in the hospital setting, but the immediate purpose of CPR is to provide effective ventilation and circulation when a patient's heart and lungs have ceased functioning.<sup>43</sup> Rapid restoration of oxygen flow to the

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standards." UNIFORM DETERMINATION OF DEATH ACT. *See also* KAN. STAT. ANN. § 77-202 (Supp. 1981), which provides:

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before any vital organ is removed for purposes of transplantation.

These alternative definitions of death are to be utilized for all purposes in this state, including the trials of civil and criminal cases, any laws to the contrary notwithstanding.

<sup>39</sup>*See Swafford v. State*, 421 N.E.2d at 601. *See note 38 supra*.

<sup>40</sup>*See Swafford v. State*, 421 N.E.2d at 601.

<sup>41</sup>*See Corday, supra note 14; Levin & Levin, CPR: Its Legal Effects*, 3 GLENDALE L. REV. 285 (1978-79).

<sup>42</sup>*Corday, supra note 14*, at 630.

<sup>43</sup>Hospital resuscitation includes the use of adjunctive equipment such as endotracheal intubation and supplemental oxygen, intravenous fluids and cardiac drugs, defibrillation, insertion of artificial cardiac pacemakers, cardiac monitoring with control of arrhythmias, and even open chest internal cardiac compression, if indicated. National Conference on Standards for Cardiopulmonary Resuscitation and Emergency Cardiac

brain is essential to prevent brain damage or brain death. The probability of brain damage after oxygen flow to the brain has ceased depends upon the speed of application of CPR.<sup>44</sup>

Physicians have an obligation to initiate CPR whenever it is medically indicated.<sup>45</sup> The American Medical Association position on CPR is that it is not indicated when death is the expected outcome of a terminal, irreversible illness, or where prolonged cardiac arrest indicates that resuscitation would be futile.<sup>46</sup> Rather, the goal of CPR is to prevent "sudden, unexpected death."<sup>47</sup> Therefore, where death is sudden and unexpected, CPR is ordinary medical care which all physicians have a legal, as well as professional, obligation to render.<sup>48</sup> When death is the natural termination of an irreversible illness, however, there is no professional obligation to initiate CPR. This implies that in this circumstance CPR is extraordinary care, which may be omitted without resultant legal liability.<sup>49</sup>

In accordance with its position on CPR, in 1974, the AMA recommended that when CPR is contraindicated for hospital patients, that physicians document this conclusion both in the patient's progress notes and on the physician's order sheet for the benefit of other health care personnel.<sup>50</sup> This order to withhold CPR has various names, including the "Do Not Resuscitate" (DNR) order,<sup>51</sup> the "No-Code" order,<sup>52</sup> and the "Order Not to Resuscitate" (ONTR).<sup>53</sup>

Recent judicial decisions<sup>54</sup> have prompted various commentators to question what procedure is proper for determining whether a DNR order can be issued.<sup>55</sup> Additionally, concern exists that tradi-

Care, *Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 227 J. A.M.A 837, 838 (1974) [hereinafter cited as *Standards for CPR*].

<sup>44</sup>Corday, *supra* note 14, at 630. If the oxygen flow is reestablished within four minutes, brain damage is unlikely. Levin & Levin, *supra* note 41, at 286-87. If reestablishment of oxygen flow is delayed from four to ten minutes, brain damage is probable. *Id.* Brain damage is almost certain if deprivation of oxygen exceeds ten minutes and may be severe enough to result in brain death. *Id.*; Corday, *supra* note 14, at 630.

<sup>45</sup>*Standards for CPR*, *supra* note 43, at 864.

<sup>46</sup>*Id.*

<sup>47</sup>*Id.*

<sup>48</sup>See notes 86-97 *infra* and accompanying text.

<sup>49</sup>*Id.*

<sup>50</sup>*Standards for CPR*, *supra* note 43, at 864.

<sup>51</sup>See *In re Quinlan*, 70 N.J. 10, 29, 355 A.2d 647, 657, *cert. denied*, 429 U.S. 922 (1976).

<sup>52</sup>See *In re Dinnerstein*, 6 Mass. App. Ct. 466, 470, 380 N.E.2d 134, 136 (1978).

<sup>53</sup>Rabkin, Gilkman & Rice, *Orders Not to Resuscitate*, 295 NEW ENG. J. MED. 364 (1976).

<sup>54</sup>*In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

<sup>55</sup>See, e.g., Baron, *Assuring "Detached But Passionate Investigation and Decis-*

tional death criteria should not or will not be recognized in the future as a result of the adoption of the brain death standard. Depending upon how the courts delineate ordinary and extraordinary treatment,<sup>56</sup> eliminating traditional death criteria could compel physicians to employ CPR for all patients, regardless of their medical prognosis.

#### IV. EUTHANASIA BACKGROUND

Whenever withholding available medical resources is contemplated, the issue of euthanasia surfaces. The word "euthanasia" is derived from the Greek word for "easy death," and is defined as "[t]he act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy."<sup>57</sup> Euthanasia is a collective concept encompassing three distinct aspects: death with dignity,<sup>58</sup> mercy killing,<sup>59</sup> and death selection.<sup>60</sup>

In the American criminal system, euthanasia is considered to be murder<sup>61</sup> because motive is generally not an element of the crime of murder.<sup>62</sup> This view of euthanasia was discussed in *People v. Conley*.<sup>63</sup> The California Supreme Court, in a discussion of malice aforethought, stated that "one who commits euthanasia bears no ill will toward his victim and believes his act is morally justified, but he nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief."<sup>64</sup>

Courts have held that even if the victim were dying at the time

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ion": *The Role of Guardians Ad Litem in Saikewicz-type Cases*, 4 AM. J.L. & MED. 111 (1978); Curran, *The Saikewicz Decision*, 298 NEW ENG. J. MED. 499 (1978).

<sup>56</sup>See notes 101-36 *infra* and accompanying text.

<sup>57</sup>BLACK'S LAW DICTIONARY 497 (5th ed. 1979).

<sup>58</sup>When used in this sense, euthanasia means letting the terminally ill die without subjecting them to the application of extraordinary medical technology. This is not synonymous with neglect: the dying patient, like all others, is given reasonable and prudent care under the circumstances. St. Martin, *Euthanasia: The Three-In-One Issue*, 27 BAYLOR L. REV. 62, 62 (1975).

<sup>59</sup>This concept encompasses the intentional use of medical technology to induce or hasten death. It includes giving a lethal drug to a terminally ill patient with the express intention of causing death, as well as withdrawing "ordinary, reasonable and prudent care." For example, allowing Downs' Syndrome children to die of pneumonia. The justification for such acts is pity: the lives and, therefore, the suffering of incurably ill or defective persons should not be prolonged. *Id.*

<sup>60</sup>This process involves the deliberate termination of lives which are no longer considered "socially useful," and which have become a burden to society. *Id.* at 62-63.

<sup>61</sup>Note, *Legal Aspects of Euthanasia*, 36 ALBANY L. REV. 674, 675 (1972).

<sup>62</sup>W. LAFAVE & F. SCOTT, HANDBOOK ON CRIMINAL LAW 200, 205 (1972). Motive, or the reason for acting is distinguished from intent. While intent is an essential element of murder, motive is not unless mandated by statute. *Id.*

<sup>63</sup>64 Cal. 2d 310, 411 P.2d 911, 49 Cal. Rptr. 815 (1966) (not a euthanasia case).

<sup>64</sup>*Id.* at 322, 411 P.2d at 918, 49 Cal. Rptr. at 822.

the defendant acted, the defendant is still guilty of homicide.<sup>65</sup> "If any life at all is left in the human body, even the least spark, the extinguishment of it is as much homicide as the killing of the most vital being."<sup>66</sup> Therefore, killing to relieve suffering is not a recognized defense to murder. Receiving the consent of the victim is not a recognized defense either.<sup>67</sup> In *People v. Roberts*,<sup>68</sup> a husband, at the request of his wife who was afflicted with multiple sclerosis, mixed poison and placed it within her reach. Though suicide was not a criminal offense in Michigan, and therefore aiding suicide could not be a crime, the defendant was found guilty of first-degree murder.<sup>69</sup>

In theory, euthanasia is homicide, but cases dealing with euthanasia reveal a chasm between the theory and the practice of the law.<sup>70</sup> This was most poignantly illustrated in *People v. Werner*.<sup>71</sup> The sixty-nine-year-old defendant who had suffocated his crippled, bedridden wife upon learning that they were being sent to a nursing home pleaded guilty to voluntary manslaughter.<sup>72</sup> The judge had the defendant withdraw his guilty plea and then acquitted Werner, saying:

Courts don't condone mercy killings and I do not, but . . . [w]e certainly have no reason to be concerned about his committing any comparable crimes or further crimes . . . I am inclined to think that a jury, if he were tried with a jury, and testimony was brought out of his devotion and care to his wife in her incurable illness and of her constant pain and suffering, the jury would not be inclined to return a verdict of guilty.<sup>73</sup>

There have been many other instances of failure to indict, acquittals, suspended sentences, and reprieves where the killer was allegedly motivated by mercy.<sup>74</sup> Thus, it seems that motive, although

<sup>65</sup>W. LAFAVE & F. SCOTT, *supra* note 62, at 532-33.

<sup>66</sup>State v. Francis, 152 S.C. 17, 149 S.E. 348, 364 (1929) (quoting 21 AMERICAN AND ENGLISH ENCYCLOPEDIA OF LAW 92 (2d ed. 1902)).

<sup>67</sup>Gurney, *Is There a Right to Die? A Study of the Law of Euthanasia*, 3 CUM.-SAM. L. REV. 235, 240 (1972).

<sup>68</sup>211 Mich. 187, 178 N.W. 690 (1920).

<sup>69</sup>*Id.* at 188, 178 N.W. at 694.

<sup>70</sup>See Morris, *Voluntary Euthanasia*, 45 WASH. L. REV. 239 (1970).

<sup>71</sup>Crim. No. 58-3656 (Cook County Ct., Ill. 1958), *discussed in* Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1214 n.95 (1973). A portion of the transcript of this case is presented in Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178, 184-87 (1966).

<sup>72</sup>See Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. at 1214.

<sup>73</sup>*Id.* at 1215 (citing Williams, *supra* note 71, at 186).

<sup>74</sup>One writer has collected ten euthanasia cases in which the victim did not re-

not a recognized defense to murder at common law, has influenced the decisions of judges and juries in euthanasia cases.<sup>75</sup> Interestingly, only two physicians have ever been indicted for alleged acts of euthanasia and both were found not guilty.<sup>76</sup> Yet a survey conducted at a Chicago medical convention revealed that sixty-one percent of those present believed that passive euthanasia was being practiced by members of the profession.<sup>77</sup> Other physicians believe the estimate to be even higher.<sup>78</sup>

## V. DETERMINING PHYSICIAN LIABILITY FOR EUTHANASIA

Euthanasia may not be illegal under all circumstances.<sup>79</sup> In determining whether a physician's actions may give rise to either criminal or civil liability, three distinct factual determinations must be made: 1) whether the death of the patient resulted from an omission or commission; 2) whether the life-saving treatment was of an ordinary or extraordinary nature; and 3) whether the patient died voluntarily or involuntarily.<sup>80</sup>

### A. *The Active-Passive Distinction*

Euthanasia can be performed by affirmative conduct which directly causes death, or by an omission or passive conduct from which death results.<sup>81</sup> It is clear from cases already cited that the common law has imposed criminal liability for active euthanasia.<sup>82</sup> A positive act to end the life of another, such as poisoning, suffocation, or injection of medication, is as illegal for a doctor as for a layman.<sup>83</sup>

quest death, and in only one of them was the defendant found guilty of first degree murder. Three defendants were acquitted by reason of insanity, three were acquitted altogether, two were found guilty of a lesser degree of homicide, and one was never indicted. Morris, *supra* note 70, at 242 n.7.

<sup>75</sup>Survey, *supra* note 71, at 1215.

<sup>76</sup>State v. Sander, (New Hampshire 1950) *discussed in* Survey, *supra* note 72, at 1214. Dr. Herman Sander injected air into his patient intravenously and charted that she died within ten minutes. *See* Survey, *supra* note 71, at 1214. In 1974, Dr. Vincent Montemarano injected potassium chloride into his unconscious patient dying of cancer of the mouth. *See* Levin & Levin, *DNR: An Objectionable Form of Euthanasia*, 49 UNIV. CIN. L. REV. 567, 575 n.70 (1980) [hereinafter cited as *DNR*].

<sup>77</sup>Note, *supra* note 61, at 674.

<sup>78</sup>*Medical Ethics: The Right to Survival, 1974: Hearing Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare*, 93d Cong., 2d Sess. 9 (1974).

<sup>79</sup>Gurney, *supra* note 67, at 240-41; *DNR*, *supra* note 76, at 568.

<sup>80</sup>*DNR*, *supra* note 76, at 568.

<sup>81</sup>Gurney, *supra* note 67, at 235.

<sup>82</sup>*See* notes 61-69 *supra* and accompanying text.

<sup>83</sup>Elkington, *The Dying Patient, The Doctor and The Law*, 13 VILL. L. REV. 740, 744 (1968).

Passive euthanasia, however, is culpable only under limited circumstances.<sup>84</sup>

The distinction between active and passive euthanasia, however, is not always clear-cut. If a patient is never placed on a mechanical ventilator and dies, this is clearly an omission. If a patient is placed on a mechanical ventilator and his physician subsequently determines that his condition is hopeless, unplugging the machine would appear to be a positive act. But, this action can also be classified as passive because the physician is omitting to provide further care.<sup>85</sup> Such is the construction that should be given to CPR with respect to terminally ill patients.

In contrast to active euthanasia, euthanasia by omission, or passive euthanasia, is culpable only under limited circumstances.<sup>86</sup> The common law has imposed criminal liability for deaths resulting from a failure to act only where the person guilty of the omission has a clear duty to act.<sup>87</sup> The duty owed must be "a legal duty and not a mere moral obligation. It must be a duty imposed by law or contract, and the omission to perform the duty must be the immediate and direct cause of death."<sup>88</sup>

A physician has no obligation to treat all prospective patients seeking medical assistance.<sup>89</sup> However, once he has initiated treatment, the law imposes a duty on him to continue such treatment as long as the case requires,<sup>90</sup> unless the patient excuses him from subsequent service, or, upon proper notice, the physician refuses to treat the patient further.<sup>91</sup> The doctor-patient relationship is basically contractual.<sup>92</sup> Unless a special agreement is expressed by the parties, the physician or surgeon impliedly contracts that he has "the reasonable and ordinary qualifications of his profession and that he will exercise reasonable skill, diligence, and care in treating the patient."<sup>93</sup> The physician's legal duty to his patient is sometimes

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<sup>84</sup>*DNR, supra* note 76, at 573.

<sup>85</sup>Foreman, *The Physician's Criminal Liability for the Practice of Euthanasia*, 27 BAYLOR L. REV. 54, 56-57 (1975).

<sup>86</sup>*DNR, supra* note 76, at 573.

<sup>87</sup>See Frankel, *Criminal Omissions: A Legal Microcosm*, 11 WAYNE L. REV. 367 (1965).

<sup>88</sup>*People v. Beardsley*, 150 Mich. 206, 209, 113 N.W. 1128, 1129 (1907).

<sup>89</sup>*Hurley v. Eddingfield*, 156 Ind. 416, 59 N.E. 1058 (1901).

<sup>90</sup>*Ricks v. Budge*, 91 Utah 307, 64 P.2d 208 (1937).

<sup>91</sup>*Worster v. Caylor*, 231 Ind. 625, 629, 110 N.E.2d 337, 339 (1953).

<sup>92</sup>*Survey, supra* note 71, at 1207.

<sup>93</sup>*Worster*, 231 Ind. at 629, 110 N.E.2d at 339. See *Shilkret v. Annapolis Emergency Hosp. Ass'n*, 276 Md. 187, 349 A.2d 245 (1975), for a discussion of the history of the strict locality rule and its evolution to the same or similar locality rule. Both rules are recognized in various states today, although ever-increasing emphasis on medical specialization has accelerated the erosion of the locality rules with a concomitant emergence of a national standard. *Id.*

couched in terms of "ordinary" care. The physician must utilize "such ordinary skill and diligence and apply the means and methods generally used by physicians and surgeons of ordinary skill and learning."<sup>94</sup>

While omission of ordinary medical treatment can result in physician liability because the physician has a legal duty to render such treatment, omission of extraordinary treatment should not have the same consequences. Lord Coleridge once stated that "[i]t would not be correct to say that every moral obligation is a legal duty; but every legal duty is founded upon a moral obligation."<sup>95</sup> Religious leaders, while condemning active euthanasia, do not advocate prolonging hopeless lives with extraordinary medical treatment.<sup>96</sup> Therefore, for lack of a moral obligation, it is likely that courts will agree that the physician has no legal duty to render extraordinary treatment to terminally ill patients.<sup>97</sup> If the court allows the motive of the physician in withholding extraordinary treatment from terminally ill patients to influence them, it is even less likely that culpability will be assigned.

To date, there have been no cases dealing with euthanasia by omission by physicians or lay persons.<sup>98</sup> There are no appellate cases

<sup>94</sup>McHugh v. Audet, 72 F. Supp. 394, 399 (M.D. Pa. 1947).

<sup>95</sup>The Queen v. Instan, [1893] 1 Q.B. 450, 453, *quoted in* People v. Beardsley, 150 Mich. at 212, 113 N.W. at 1130 (1907).

<sup>96</sup>The duty of employing ordinary care has been recognized by the religious community. Pope Pius XII spoke to the International Congress of Anesthesiologists in November, 1957, and stated:

Natural reason and Christian morals say that man [and whoever is entrusted with the task of caring for his fellowman] has the right and duty in case of serious illness to take the necessary treatment for the preservation of life and health . . . .

But normally one is held to use only ordinary means—according to circumstances of persons, places, times and culture—that is to say, means that do not involve any grave burden on oneself or another.

Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723, 734 (1973) (quoting 4 THE POPE SPEAKS 393, 395-96 (Spring 1958)). The Bishops of the Netherlands have set forth the policy that:

[t]here is no absolute need to prolong indefinitely a life which has been despaired of, by means of medicines and machines, especially if the life in question is purely vegetal, without signs of human reaction. In the latter case above all, extraordinary means may be omitted and the natural process allowed to take its course.

Survey, *supra* note 71, at 1209.

These religious leaders have acknowledged the distinction between ordinary and extraordinary treatments. Their statements lend support to the proposition that there is no moral obligation to render extraordinary care, and that what is extraordinary care will depend on the patient and the circumstances.

<sup>97</sup>Foreman, *supra* note 85, at 57; Gurney, *supra* note 67, at 247-48.

<sup>98</sup>Fletcher, *Legal Aspects of the Decision Not to Prolong Life*, 203 J. A.M.A. 65,

to date dealing with criminal liability for failure to perform a contract for medical services.<sup>99</sup> However, physicians have been held civilly liable for failure to render ordinary treatment and care when they had previously accepted the patients for treatment.<sup>100</sup> Therefore, the crux of the problem in deciding the legality of withholding medical treatment, specifically CPR, is whether the treatment is extraordinary or ordinary for that particular patient.

### B. *Extraordinary-Ordinary Treatment*

The distinction between ordinary and extraordinary care is not clear. It has neither been expressly recognized in case or statutory law, nor has it been adequately analyzed in legal literature.<sup>101</sup> One author states that the contemporary distinction between ordinary and extraordinary medical care focuses on death.<sup>102</sup> That is, any treatment rendered before death is ordinary care, and any treatment rendered after death is extraordinary.<sup>103</sup> If accepted by the courts in those states which define death only in terms of permanent cessation of brain function, this definition would require physicians to administer CPR to all patients whose heart or respirations have ceased, regardless of their medical prognosis. Failure to administer CPR would constitute withholding ordinary medical care, because the patient would not be "dead" under the brain death standard. Because a physician is under a legal duty to render ordinary care to his patients, withholding CPR would result in civil and criminal liability under the common law.<sup>104</sup>

Another legal commentator defines ordinary care as "those medical and surgical procedures that would normally be applied in situations not involving physically or mentally handicapped

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66 (1965). There have been cases of murder by omission involving lay persons. In general, the defendants were negligent in carrying out a legal duty owed their victims, and were found guilty. See *State v. Behm*, 72 Iowa 533, 34 N.W. 319 (1887) (a mother was convicted of manslaughter for exposing her infant child to the elements without protection); *State v. Smith*, 65 Me. Rep. 257 (1876) (a husband neglected to provide shelter and clothing for his insane wife, whom he left in a room without heat during winter); *Territory v. Manton*, 8 Mont. 95, 19 P. 387 (1888) (a husband was found guilty of manslaughter for leaving his intoxicated wife lying in the snow).

<sup>99</sup>Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213, 226 (1975).

<sup>100</sup>These abandonment cases center on patients who would have recovered normally with proper medical attention, not patients whose conditions were terminal. Survey, *supra* note 71, at 1208. See generally Annotation, 57 A.L.R.2d 432 (1958) (abandonment cases).

<sup>101</sup>Robertson, *supra* note 99, at 235.

<sup>102</sup>DNR, *supra* note 76, at 569.

<sup>103</sup>*Id.*

<sup>104</sup>*Id.* at 571.

persons."<sup>105</sup> This definition attempts to strictly categorize treatment modes as either ordinary or extraordinary, without considering individual patient factors. If the courts adopted this definition, physicians would be compelled to administer CPR to all patients regardless of prognosis.

The most frequently cited definitions of ordinary and extraordinary care were developed by theologians:

Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience. Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit.<sup>106</sup>

Pope Pius XII stated that ordinary care will depend upon "the circumstances of person, place, times and culture."<sup>107</sup> This has been interpreted by some physicians to mean reasonable care.<sup>108</sup> While the term "reasonable" is as ambiguous as the term "ordinary," it does imply that individual patient factors should be considered in delineating the scope of ordinary care.

Although not specifically referred to in the cases, courts appear to be utilizing these latter two concepts in defining extraordinary care. That is, the courts are considering the present condition and prognosis of each patient in addition to the effect the treatment at issue will have upon the patient's condition and prognosis, sometimes called the expected benefit.

In *In re Quinlan*,<sup>109</sup> the New Jersey Supreme Court noted that the proliferation of modern technology has created a dilemma for the medical profession as it searches for a definitive policy on what treatments are required in the absence of legislative and judicial guidelines.<sup>110</sup> The court recognized that physicians have refused to prolong the death of a patient when it is clear that such "therapy" offers neither human nor humane benefit.<sup>111</sup> While stating that this

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<sup>105</sup>Robertson, *supra* note 99, at 213 n.1.

<sup>106</sup>*Id.* at 236 (quoting Kelly, *The Duty to Preserve Life*, 12 THEOL. STUDIES 550 (1951)). See Survey, *supra* note 71, at 1209.

<sup>107</sup>Louisell, *supra* note 96, at 734.

<sup>108</sup>*Moral, Ethical and Legal Questions of Extraordinary Health Care, 1975: Hearing Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, 94th Cong., 1st Sess. 19 (1975).*

<sup>109</sup>70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

<sup>110</sup>*Id.* at 47, 355 A.2d at 667.

<sup>111</sup>*Id.*

attitude represents a realistic perspective on the meaning of life and death, and that it is respectful of the Judeo-Christian tradition of the sacredness of human life, the court pointed out that the implementation of this attitude in the face of sophisticated, life-sustaining devices is difficult.<sup>112</sup> The court stated:

For those possibly curable, such devices are of great value, and as ordinary medical procedures, are essential . . . . [T]hey are necessary because of the ethic of medical practice [healing the sick] . . . . [T]he use of the same respirator or like support could be considered "ordinary" in the context of the possibly curable patient, but "extraordinary" in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient.<sup>113</sup>

In *Superintendent of Belchertown State School v. Saikewicz*,<sup>114</sup> the Supreme Judicial Court of Massachusetts evaluated multiple factors in determining whether chemotherapy should be withheld from a sixty-seven-year-old mentally retarded man with leukemia.<sup>115</sup> The court considered the patient's capacity to understand his present situation and prognosis, his inability to cooperate with the chemotherapy, and his inability to understand the disruption in his stable environment, as well as the invasiveness, pain potential and probable side effects of the treatment itself.<sup>116</sup> While not expressly stating that chemotherapy was extraordinary treatment, the court did recognize that it was a life-prolonging rather than a life-saving treatment.<sup>117</sup> The court stated that:

[W]e should not use *extraordinary* means of prolonging life or its semblance when, after careful consideration, consultation and 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.<sup>118</sup>

In determining whether blood transfusions should be withheld from a mentally retarded patient with cancer of the bladder, the

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<sup>112</sup>*Id.* at 47-48, 355 A.2d at 667.

<sup>113</sup>*Id.* at 48, 355 A.2d at 667-68.

<sup>114</sup>373 Mass. 728, 370 N.E.2d 417 (1977).

<sup>115</sup>*Id.* at 731-35, 370 N.E.2d at 430-32.

<sup>116</sup>*Id.*, 370 N.E.2d at 430-32.

<sup>117</sup>*Id.* at 745, 370 N.E.2d at 428.

<sup>118</sup>*Id.* at 738, 370 N.E.2d at 424 (quoting Lewis, *Machine Medicine and Its Relation to the Fatally Ill*, 206 J. A.M.A. 387 (1968)).

New York Court of Appeals in *In re Storar*<sup>119</sup> considered the degree of pain and fear caused by the procedure and the effect of the transfusions on Storar's physical and mental status.<sup>120</sup> With transfusions, Storar was aware of his surroundings, recognized people familiar to him, and functioned essentially as he always had.<sup>121</sup> The court conceded that Storar found the transfusions disagreeable, that he could not comprehend the purpose of the treatment, and that he had to be sedated to ensure his cooperation.<sup>122</sup> However, the court determined that Storar's discomfort was not excessive when balanced against the benefits received from the transfusions.<sup>123</sup> Therefore, the appellate court overruled the lower court's decision and ordered the transfusions to continue.<sup>124</sup> As in *Saikewicz* and *Quinlan*, the *Storar* court weighed multiple factors in reaching its decision.

The Massachusetts Court of Appeals followed a similar pattern of reasoning in *In re Spring*.<sup>125</sup> Earle Spring was a seventy-eight-year-old man with organic brain syndrome and end-stage renal failure undergoing hemodialysis treatment three days a week for five hours each day.<sup>126</sup> His wife and son petitioned the court to have the hemodialysis treatments discontinued. In reaching its decision the lower court considered numerous factors: 1) the patient had led an active, robust, independent life prior to becoming ill; 2) he had fallen into a pitiable state of physical dependence and mental instability; 3) physicians expected no improvement in either his physical or mental condition, but instead expected further deterioration; 4) the dialysis treatments exacted a significant toll in terms of discomfort and were needed frequently for hours at a time; 5) the patient had no understanding of the nature and purpose of the treatments and was incapable of cooperating; 6) the patient's wife and son believed that the patient would not want the treatments continued under the circumstances; and 7) the attending physician recommended discontinuance of the treatment.<sup>127</sup> The lower court ordered the attending physician, wife, and son to decide whether to continue treatment.<sup>128</sup> This decision was upheld by the appellate court after a review of the same circumstances enumerated by the lower court.<sup>129</sup>

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<sup>119</sup>52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (N.Y. 1981).

<sup>120</sup>*Id.* at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

<sup>121</sup>*Id.* at 374, 375 n.5, 420 N.E.2d at 69, 70 n.5, 438 N.Y.S.2d at 271; 272 n.5.

<sup>122</sup>*Id.* at 375, 420 N.E.2d at 69, 438 N.Y.S.2d at 271-72.

<sup>123</sup>*Id.* at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

<sup>124</sup>*Id.* at 383, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.

<sup>125</sup>399 N.E.2d 493 (Mass. App. Ct. 1979).

<sup>126</sup>*Id.* at 495.

<sup>127</sup>*Id.* at 498.

<sup>128</sup>*Id.* at 495.

<sup>129</sup>*Id.* at 498-504.

Prior to *Spring*, however, the Massachusetts Supreme Judicial Court had ordered dialysis treatments to be continued for the benefit of a twenty-four-year-old prisoner in *Commissioner of Correction v. Myers*.<sup>130</sup> Myers was in good physical and mental health except for his renal failure and was an excellent kidney transplant candidate.<sup>131</sup> The court determined that dialysis was "relatively painless."<sup>132</sup> Therefore, the court ordered hemodialysis continued over Myers' objections.<sup>133</sup> These two Massachusetts cases illustrate that the same type of treatment may be classified as ordinary or extraordinary depending upon the patient and his prognosis, the invasiveness, pain and potential side effects of the treatment, and the benefit expected from continuing the treatment.

While the cases in this area do not expressly refer to the treatment modes as ordinary or extraordinary, the fact that the *Quinlan*, *Saikewicz*, and *Spring* courts allowed the treatments to be withheld indicates that the courts deemed them extraordinary in nature, for physicians always have a legal duty to render ordinary care. Concomitantly, the fact that the *Myers* and *Storar* courts ordered continuance of the treatments in question indicates that those courts considered the treatments to be ordinary under the circumstances, for there is no moral or legal duty to render extraordinary care.

It has been stated that on the basis of the *Saikewicz* decision the "reasonable hope of benefit" test is not valid for determining whether care is ordinary or extraordinary.<sup>134</sup> However, in analyzing *Saikewicz*, *Storar*, *Spring* and *Myers*, it is clear that the courts have relied upon the "reasonable hope of benefit" test. The *Saikewicz* court firmly rejected the premise that the quality of a life equals the value of that life, but also stated that the "'quality of life' should be understood as a reference to the continuing state of pain and disorientation precipitated by the . . . treatment."<sup>135</sup> Thus, the court considered the pain and other side effects of chemotherapy in addition to the potential effect of the treatment on the life of the individual.<sup>136</sup> The courts in *Storar*, *Spring*, and *Myers* also evaluated the benefit to be derived by the patient from the specific therapy in

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<sup>130</sup>399 N.E.2d 452 (Mass. 1979).

<sup>131</sup>*Id.* at 454.

<sup>132</sup>*Id.*

<sup>133</sup>*Id.* at 458. The lower court found that Myers' refusal of dialysis was unrelated to his disease, the nature or effects of the dialysis treatments, or any religious objection to the treatment. *Id.* at 454. "Rather, . . . Myers' refusal . . . constituted a form of protest against his placement in a medium, as opposed to a minimum security prison." *Id.* Therefore, his right to refuse treatment did not outweigh the state's interest in preserving his life and maintaining order in the prisons. *Id.* at 457.

<sup>134</sup>*DNR*, *supra* note 76, at 569.

<sup>135</sup>373 Mass. at 754, 370 N.E.2d at 432.

<sup>136</sup>*See* notes 115-16 *supra* and accompanying text.

question. Therefore, the "reasonable hope of benefit" test is legally valid and supported by case law.

1. *The Physician's Responsibility.*—Ultimately, the difference between ordinary and extraordinary treatment must be delineated by the medical profession itself.<sup>137</sup> This is because the physician must conform his practice of medicine to the standards of customary medical practice—a continually changing standard.<sup>138</sup> In each of the five cases discussed above, the courts considered expert medical testimony from the attending physicians regarding the side effects of and expected benefit from the treatments in question. Though what is ordinary or extraordinary treatment must still be decided on a case by case basis, the judicial system is gradually establishing guidelines. The cases decided after *In re Quinlan* should be reassuring to physicians, for in them the courts have followed the medical recommendations of the attending physicians.<sup>139</sup>

2. *CPR as Extraordinary Care.*—Because CPR is not considered standard or sound medical practice in patients whose cardiac or respiratory arrest occurs as the anticipated or expected end of a terminal illness,<sup>140</sup> it seems logical that courts will allow CPR to be withheld from terminally ill patients. The American Medical Association has stated that:

[t]he purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death. CPR is not indicated in certain situations such as in cases of terminal irreversible illness where death is not unexpected or where prolonged cardiac arrest dictates the futility of resuscitative efforts. Resuscitation in these circumstances may represent a positive violation of an individual's right to die with dignity.<sup>141</sup>

This medical philosophy of care was upheld by the Massachusetts Court of Appeals in *In re Dinnerstein*.<sup>142</sup> The issue in *Dinnerstein* was whether a physician attending an incompetent terminally ill patient can legally withhold CPR in the event of a cardiac or respiratory

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<sup>137</sup>Horan, *Euthanasia, Medical Treatment and the Mongoloid Child: Death as a Treatment of Choice*, 27 BAYLOR L. REV. 76, 82 (1975).

<sup>138</sup>*Id.*

<sup>139</sup>In *In re Quinlan* the attending physicians did not feel that Karen's condition would improve with continuing artificial ventilation. Her condition was described as a "chronic persistent vegetative state" for which there is no cure. However, the treating physicians and several other qualified experts testified that removal from the respirator would not conform to medical practices, standards and traditions. 355 A.2d at 654-55.

<sup>140</sup>*Standards for CPR, supra* note 43, at 864.

<sup>141</sup>*Id.*

<sup>142</sup>6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).

arrest.<sup>143</sup> Shirley Dinnerstein had Alzheimer's disease, a degenerative disease of the brain, in addition to osteoporosis, coronary artery disease and hypertension.<sup>144</sup> Her life expectancy was no more than a year, but her attending physicians felt she could suffer a respiratory or cardiac arrest at anytime.<sup>145</sup> The court stated that it is within the competence of the medical, not the judicial, profession to determine what measures are necessary to ease the imminent passing of a terminally ill patient in view of the patient's history, condition and family's wishes.<sup>146</sup>

Even so, the court advocated consideration of the patient's present physical and mental state, his or her prognosis, and the anticipated benefit to be derived from application of treatment in deciding whether CPR is extraordinary treatment and can be withheld.<sup>147</sup> The court noted that "cardiac or respiratory arrest will signal the arrival of death for the overwhelming majority of persons whose lives are terminated by illness or old age."<sup>148</sup> Even if successful, resuscitation does not cure or abate the illnesses that brought the patients to the threshold of death and will only prolong their lives until they experience another cardiac or respiratory arrest.<sup>149</sup> Therefore, with respect to terminally ill patients, CPR is not a life-saving or even a life-prolonging technique in the sense that it can restore a patient to "normal, integrated, functioning, cognitive existence."<sup>150</sup> An analysis of these statements leads to the conclusion that CPR can be withheld from terminally ill patients as extraordinary medical treatment.

As discussed earlier, what is ordinary or extraordinary treatment for a particular patient can be determined only after considering all the circumstances concerning the patient's illness, including his present physical and mental status, his family's wishes, his medical prognosis, the hope of benefit from treatment, and relevant medical standards of care. Even CPR should be subjected to such an assessment in determining whether it is appropriate medical care for a particular patient. When the relevant standard of medical care, the poor prognosis and the lack of any real benefit are considered, it is clear that CPR for terminally ill patients is extraordinary care and can, therefore, be legally withheld.

Furthermore, when this approach is taken in determining what

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<sup>143</sup>*Id.* at 466, 380 N.E.2d at 134.

<sup>144</sup>*Id.* at 466-69, 380 N.E.2d at 134-35.

<sup>145</sup>*Id.* at 468, 380 N.E.2d at 135.

<sup>146</sup>*Id.* at 475, 380 N.E.2d at 139.

<sup>147</sup>*Id.*, 380 N.E.2d at 138-39.

<sup>148</sup>*Id.* at 470, 380 N.E.2d at 136.

<sup>149</sup>*Id.* at 474, 380 N.E.2d at 139.

<sup>150</sup>*Id.*, 380 N.E.2d at 138.

is ordinary or extraordinary care, the brain death standard will not affect the legality of the DNR order in those states which have adopted permanent cessation of brain function as a definition of death. The prognosis and present condition of the terminally ill patient does not change merely because a different criterion for determining the time of death has been adopted by a state's courts or legislature. The brain death standard neither contributes to the expected benefit to be derived from CPR for a terminal patient, nor affects the relevant medical standard of care. Thus, even under a brain death definition of death, CPR can be considered extraordinary care for terminally ill patients. While extraordinary care can theoretically be withheld without the consent of the patient because the physician has no duty to render it, from a practical standpoint, the physician should obtain the consent of the patient or ensure that it can be implied from the circumstances.<sup>151</sup>

### C. Voluntary - Involuntary Distinction

When the patient is competent, there is clear authority that the patient has the right to withdraw consent and refuse any life-saving treatment, even when the result will be certain death and the prognosis with treatment is good.<sup>152</sup> This right to refuse treatment has not been limited to the terminally ill.<sup>153</sup> If a terminal patient is competent and able to express his wishes regarding his current and

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<sup>151</sup>See notes 152-74 *infra* and accompanying text.

<sup>152</sup>See, e.g., *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (court would not override patient's religiously motivated decision to refuse blood transfusion, even though it could be considered an "unwise, foolish or ridiculous decision"); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978) (competent 72-year-old patient suffering from gangrene in both legs had right to refuse life-saving surgery where the probability of operative recovery was good and where without surgery patient would die within weeks); *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966) (court refused to order amputation of leg of elderly woman where there was conflicting medical opinion whether the amputation would kill, cure or lead to further surgery); *Erikson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962) (court would not order blood transfusions for Jehovah Witness who consented to surgery but refused any transfusions); *In re Yetter*, 62 Pa. D. & C.2d 619 (Northampton County Ct. 1973), discussed in Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 3 (1975) (court upholds patient's decision to refuse breast biopsy and possible cancer surgery). See generally Byrn, *supra*.

<sup>153</sup>See note 152 *supra*. While the state does have an interest in protecting the life of the individual, individuals have a constitutional right to privacy which may be asserted to prevent unwanted infringements on bodily integrity. *In re Spring*, 399 N.E.2d at 455-56. As with all other rights, the individual's right to privacy is not absolute and must be balanced against countervailing state interests; that is, the preservation of life, the prevention of suicide, the protection of the interests of innocent third parties, and the maintenance of the ethical integrity of the medical profession. *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425.

future medical treatment, the physician has the duty to inform the patient of his condition, prognosis and treatment alternatives.<sup>154</sup> The competent patient's informed refusal of any ordinary or extraordinary measure is a legally supported decision.

Problems arise when a patient has never been competent because of age, mental illness, or retardation and when a patient who was competent at one time becomes incompetent due to his disease process, medication, or age.<sup>155</sup> The court in *Saikewicz* stated that "[t]o protect the incompetent person . . . 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."<sup>156</sup> In protecting the incompetent's right to life, courts have overruled objections to life-saving treatment, particularly when the chances for recovery have been great and the degree of bodily invasion relatively minor.<sup>157</sup> With regard to treatment that is at best life-prolonging, traditional medical practice has been to defer to the wishes of family members, who, in all likelihood, will be greatly influenced by the physician's recommendations.<sup>158</sup> The judicial system, however, has been involved in such decision making for the incompetent patient with increasing frequency over the last few years.<sup>159</sup>

The case of Karen Ann Quinlan was the first case to recognize the

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<sup>154</sup>The doctrine of informed consent requires that every competent adult patient be given information on the possible risks and benefits involved in proposed medical treatment. The patient must consent before treatment is rendered. See Comment, *Informed Consent for the Terminal Patient*, 27 BAYLOR L. REV. 111 (1975).

<sup>155</sup>Several states have enacted living will statutes which may cover this situation if all provisions are met. See generally Note, *Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute*, 64 IOWA L. REV. 573 (1979); Note, *Death With Dignity and the Terminally Ill: The Need for Legislative Action*, 4 NOVA L.J. 257 (1980); Note, *The Kansas Natural Death Act*, 19 WASHBURN L.J. 519 (1980).

<sup>156</sup>373 Mass. at 746, 370 N.E.2d at 428.

<sup>157</sup>See, e.g., *In re Schiller*, 148 N.J. Super. 168, 372 A.2d 360 (Ch. Div. 1977) (court appointed special guardian to consent to emergency, life-saving amputation for a 67-year-old patient suffering from diabetes and arteriosclerosis); *Long Island Jewish-Hillside Med. Center v. Levitt*, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973) (court appointed relative as guardian and ordered life-saving amputation for an 84-year-old patient considered a good surgical risk); *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197 (Tenn. Ct. App.), cert. denied, 436 U.S. 923 (1978) (court rejected 72-year-old incompetent patient's request to grant stay of lower court order authorizing life-saving amputation).

<sup>158</sup>Relman, *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENG. J. MED. 508, 509 (1978).

<sup>159</sup>See, e.g., *In re Spring*, 399 N.E.2d 493 (Mass. App. Ct. 1979); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

right to withhold life-sustaining treatment from an incompetent individual. The New Jersey Supreme Court focused on Karen's medical prognosis in reaching its decision. She was "in a chronic persistent vegetative state," unlikely to ever regain consciousness, with no known treatment likely to cure or improve her condition.<sup>160</sup> The New Jersey court preferred that the decision to withhold life-prolonging treatment remain with the physician and the family,<sup>161</sup> but required concurrence by a hospital ethics committee before life-sustaining measures could be withdrawn.<sup>162</sup> The court rejected the judiciary making such decisions, characterizing such involvement as a "gratuitous encroachment upon the medical profession's field of competence,"<sup>163</sup> in addition to being "impossibly cumbersome."<sup>164</sup>

The Massachusetts Supreme Judicial Court in the *Saikewicz* case disagreed with the New Jersey decision. The court stated:

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 is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated . . . .<sup>165</sup>

In *Saikewicz*, the Massachusetts Supreme Judicial Court employed the "substituted judgment" test to determine what Saikewicz himself would have wanted. The common law doctrine of substituted judgment has long been used to allow courts and guardians to make a variety of decisions for an incompetent.<sup>166</sup> In utilizing the substi-

<sup>160</sup>70 N.J. at 24-26, 355 A.2d at 654-55.

<sup>161</sup>*Id.* at 54, 355 A.2d at 671. Karen had made statements before becoming ill that she did not want to be maintained on a ventilator in a vegetative state. These statements were of no consequence to the courts' opinion as both courts decided that the statements lacked probative weight because of their remoteness from an actual situation. *Id.* at 21-22, 355 A.2d at 653.

<sup>162</sup>The ethics committee was seen as serving several purposes: 1) procedural safeguard for the incompetent, 2) an insurer that no civil or criminal liability would arise, and 3) a method of diffusing responsibility. *Id.* at 54, 355 A.2d at 671.

<sup>163</sup>*Id.* at 50, 355 A.2d at 669.

<sup>164</sup>*Id.*

<sup>165</sup>373 Mass. at 759, 370 N.E.2d at 435.

<sup>166</sup>See generally Schultz, Swartz & Appelbaum, *Deciding Right-To-Die Cases Involving Incompetent Patients: Jones v. Saikewicz*, 11 SUFFOLK U.L. REV. 936 (1977).

tuted judgment test, the court substitutes its judgment for that of the incompetent person. According to *Saikewicz*, the court order should read that the probate judge is "satisfied that the incompetent individual would . . . have chosen to forego potentially life-prolonging treatment . . ." <sup>167</sup> If the judge is not so persuaded, or finds that the interests of the state require it, then treatment will be ordered. <sup>168</sup> The medical community was affronted by the court's opinion, which in fact declared that routine medical decisions could be reviewed by the courts. <sup>169</sup> Unfortunately, the court's language was misconstrued to mean that every life or death decision needs to be overseen by a court of law. The Massachusetts Court of Appeals attempted to clarify this issue in *In re Dinnerstein*.

In *Dinnerstein*, the court held that the *Saikewicz* decision requiring court determination before treatment can be withheld from an incompetent patient did not apply to withholding CPR from terminally ill patients. The court stated:

[T]he *Saikewicz* case, if read to apply to the natural death of a terminally ill patient by cardiac or respiratory arrest, would require attempts to resuscitate dying patients in most cases, without exercise of medical judgment, even when that course of action could aptly be described as a pointless, even cruel prolongation of the act of dying. <sup>170</sup>

The *Dinnerstein* court felt that *Saikewicz* is relevant only when death is not imminent and the treatment in question offers a life-prolonging or life-saving alternative. <sup>171</sup> A life-prolonging treatment does more than merely suspend the act of dying. At the very least it provides a remission of symptoms enabling a return towards "a normal, functioning, integrated existence." <sup>172</sup> Therefore, the *Dinnerstein* court, like the *Quinlan* court, affirmed that decisions based solely on medical prognosis are to be made by the physician with the approval of the patient's family. "[W]hat measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient" is a medical decision, not a judicial one. <sup>173</sup> The physician's decision is subject to court review only to the extent that he may have negligently failed to exercise the degree of care expected from an average, qualified practitioner. <sup>174</sup>

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<sup>167</sup>373 Mass. at 757, 370 N.E.2d at 434.

<sup>168</sup>*Id.*

<sup>169</sup>Baron, *supra* note 55, at 115-16; Curran, *supra* note 55, at 500.

<sup>170</sup>6 Mass. App. Ct. at 473, 380 N.E.2d at 137.

<sup>171</sup>*Id.* at 474, 380 N.E.2d at 138.

<sup>172</sup>*Id.*

<sup>173</sup>*Id.*, 380 N.E.2d at 139.

<sup>174</sup>*Id.*

### D. Summarizing Physician Liability

It is evident that a positive act to end a person's life is as illegal for a physician as it is for a layman, whether the act is performed at the request of the patient or not.<sup>175</sup> Active euthanasia can result in civil and criminal liability. It is equally evident that neither civil nor criminal liability attaches for withholding ordinary or extraordinary medical treatment if the patient consents to the withholding in agreement with the physician, or refuses recommended treatment in the exercise of his right to privacy.<sup>176</sup> Absent a patient's refusal of ordinary care, however, the physician is legally obligated to render that care as part of his professional contract with the patient.<sup>177</sup> Such is the standard of care to which physicians are held. Failure to render ordinary treatment to either an incompetent or competent patient can result in criminal liability as well as civil liability under negligence and abandonment theories.<sup>178</sup> Withholding extraordinary treatment from the incompetent patient, however, remains a cloudy area of the law.<sup>179</sup> There is no moral duty to render extraordinary care and because legal duties generally are founded on moral obligation,<sup>180</sup> there is no legal duty to render extraordinary care. Therefore, determining which treatments are ordinary and which are extraordinary becomes crucial in determining legal liability.

This distinction must be drawn on a patient by patient basis, for what may be ordinary treatment for one person may indeed be extraordinary for another.<sup>181</sup> It is evident from the cases that courts are employing the "reasonable hope of benefit" test and evaluating

<sup>175</sup>See notes 64-69 *supra* and accompanying text.

<sup>176</sup>See notes 152-55 *supra* and accompanying text.

<sup>177</sup>See notes 89-94 *supra* and accompanying text.

<sup>178</sup>*Id.*

<sup>179</sup>This chart presents a comprehensive summary of the law:

Patient Acquiescence	Physician's Act	Degree of Care	Liability
Voluntary	Positive Act		Civil and Criminal Liability
Involuntary			
Voluntary (includes refusal)	Passive (withholding)	Ordinary	No Liability
		Extraordinary	
Involuntary	Passive (withholding)	Ordinary	Civil and Criminal Liability
		Extraordinary	?

<sup>180</sup>See notes 95-97 *supra* and accompanying text.

<sup>181</sup>See *In re Quinlan*, 70 N.J. at 48, 355 A.2d at 668.

multiple patient factors in deciding what treatment is extraordinary and therefore can be withheld.<sup>182</sup> The primary factors to be considered include the patient's prognosis, his present physical and mental status, the expected benefit to be derived from the treatment in question, and the standard of customary medical practice.<sup>183</sup> When applicable, family wishes, the patient's ability to understand the need for and to cooperate with the treatment, as well as the invasiveness, pain potential and side effects of the treatment itself should be evaluated.<sup>184</sup> In short, all circumstances bearing on the patient and the treatment are to be considered.

While the status of other treatments, such as hemodialysis or chemotherapy, may be in question, the legal status of CPR in relation to the terminally ill patient has been delineated by the Massachusetts Court of Appeals in *In re Dinnerstein*. The court held that CPR is extraordinary treatment for terminally ill patients and can be withheld without fear of liability.<sup>185</sup> If the terminally ill patient is competent, obviously his wishes for treatment will be controlling. If a patient is incompetent, however, the decision-maker must evaluate the previously defined factors. A terminally ill patient's prognosis is hopeless; he is not going to improve. Therefore, CPR is not going to afford him any benefit. Because the ethic of the medical profession includes healing and providing comfort for the sick, it is likely that a terminal patient's physical condition would be quite debilitated at the time medical practitioners determine that CPR is no longer appropriate for the patient. The American Medical Association has set forth the purpose for which CPR has been developed and states that resuscitating terminally ill patients is not sound medical practice.<sup>186</sup>

Individual states addressing the issue have reached differing conclusions as to whether the courts need to be involved in decisions regarding withdrawal or withholding of life-prolonging treatment from incompetent patients. However, while the *Dinnerstein* court was adamant that the courtroom was the appropriate forum for selecting meaningful life-prolonging treatment alternatives, it held that whether to initiate CPR in terminally ill patients was strictly a medical decision to be made in conjunction with the patient's family.<sup>187</sup> Prior judicial approval is not needed to withhold CPR from terminally ill patients because it is not meaningful treatment for

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<sup>182</sup>See notes 101-51 *supra* and accompanying text.

<sup>183</sup>See notes 114-36 *supra* and accompanying text.

<sup>184</sup>*Id.*

<sup>185</sup>6 Mass. App. Ct. at 466, 380 N.E.2d 134.

<sup>186</sup>*Standards for CPR, supra* note 43, at 864.

<sup>187</sup>6 Mass. App. Ct. at 474, 380 N.E.2d at 139.

this group of patients.<sup>188</sup> This indicates that while physicians should consult with family members about a DNR order, resorting to the courts is unnecessary if all are in agreement.

Massachusetts has not adopted a brain death standard of death to date. Therefore, states that have not yet adopted brain death as a definition of death can look directly to the Massachusetts case of *In re Dinnerstein* for guidance on the DNR issue. When patients are terminally ill, CPR can be withheld as extraordinary treatment without fear of liability if the physician and family members agree that this is appropriate.

Montana, Arkansas and Tennessee have statutes defining death only in terms of permanent cessation of brain function and activity.<sup>189</sup> However, the traditional definition of death has not been eliminated by the brain death statutes or judicially abrogated in any of these states. If the courts in these states adopt the definition of extraordinary care as treatment rendered only after death, then having the brain death standard alone possibly could create a higher standard of care for physicians.<sup>190</sup> If a person is not dead until all brain function has ceased, then he is still "alive" for a brief period of time after his heart and respirations have arrested. During this time, which is going to vary with each individual, all possible treatments, including CPR, would be ordinary and physicians would have a legal duty to render that care.

If, however, the courts in these three states follow the guidelines established by other courts and, in determining what is ordinary and extraordinary care, evaluate multiple factors, including patient prognosis and the expected benefit of treatment, then CPR for terminally ill patients will be extraordinary treatment. The prognosis and present condition of the terminally ill patient does not improve merely because a different criterion for determining the time of death has been adopted. Additionally, the brain death standard neither contributes to the expected benefit to be derived from CPR for a terminal patient, nor affects the usual standard of medical care. More importantly, it is likely that these courts would retain the traditional definition of death, that is, cessation of heartbeat and respirations, if presented with the issue because it was not specifically eliminated by the statute.

Furthermore, the majority of states have expressly retained the traditional criteria for defining death in their death definition statutes, and numerous organizations recommend this approach.<sup>191</sup>

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<sup>188</sup>*Id.*

<sup>189</sup>See note 38 *supra* and accompanying text.

<sup>190</sup>*DNR*, *supra* note 76, at 571.

<sup>191</sup>See note 38 *supra*.

Although some writers find this situation confusing, in ordinary situations the traditional criteria should be adequate for determining death.<sup>192</sup> The brain death standard comes into play only when the patient has suffered severe brain damage from one of many causes.<sup>193</sup> Therefore, even in states enunciating only a brain death definition in their statutes, CPR for terminally ill patients should be classified as extraordinary treatment whether extraordinary treatment is determined by evaluating individual patient factors or by drawing a line at death. Thus, even in these states there should be no physician liability for failure to resuscitate terminally ill patients.

In states which have expressly retained the traditional definition of death in addition to adopting a brain death definition, CPR for terminally ill patients is extraordinary care if the standards for determining extraordinary care as set forth in this Note are adopted, or if courts draw the ordinary-extraordinary line at death. Furthermore, Kansas and states which choose to model their definition of death statutes after the Kansas statute expressly provide immunity for physicians who have not rendered CPR to the terminally ill. The statute states in part that "[a] person will be considered medically and legally dead if, . . . there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused . . . these functions to cease, . . . attempts at resuscitation are considered hopeless."<sup>194</sup> Thus, with the legality of the DNR order recognized by the legislature, administering CPR becomes a purely medical decision, "based on ordinary standards of medical practice."<sup>195</sup>

## VI. CONCLUSION

As long as courts continue to classify medical treatment as extraordinary or ordinary on the basis of individual patient factors and circumstances, CPR for terminally ill patients will remain extraordinary treatment. This group of patients does not benefit from resuscitative measures; CPR does not provide them meaningful prolongation of life. The brain death standard does not alter the uselessness of this technological advance for terminally ill patients. Therefore, physicians may withhold CPR from a competent terminally ill patient with that patient's consent, or from an incompetent terminally ill patient with the consent of the family. While concurrence by hospital ethics committees may be morally and ethically ad-

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<sup>192</sup>Ufford, *supra* note 8, at 231.

<sup>193</sup>Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *supra* note 6.

<sup>194</sup>KAN. STAT. ANN. § 77-202 (Supp. 1979). See note 38 *supra* for the full text.

<sup>195</sup>*Id.*

visible, such a requirement has not yet been imposed on the medical profession. The *Quinlan* court required the agreement of the ethics committee for actively removing life-support systems from the patient. The *Dinnerstein* court emphasized that the *Saikewicz* decision mandating judicial review of medical decisions to withhold medical treatment applies only when death is not imminent. Therefore, familial consent is sufficient at this time for withholding CPR from incompetent terminally ill patients.

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