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EXAMINING EUTHANASIA: A LEGAL AND CONSTITUTIONAL ANALYSIS OF RIGHT TO DIE DECISIONS

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ABSTRACT

This essay distinguishes between several end-of-life actions, focusing on euthanasia. The study accomplishes four objectives. First, it identifies factors defining euthanasia. Second, it analyzes the latter topic from the perspective of patient rights, state interests, and standards of evidence. Third, the article examines a series of state court rulings and how these decisions have influenced legal and constitutional thought. Finally, the study recommends integrating the judicial approach utilized here with ethical and public policy perspectives..

Key Words: Euthanasia, Right to Die.

1. INTRODUCTION

The courts have frequently been called upon to approve and sanction the discontinuance of a patient's life support systems due to a variety of issues stemming from legal, ethical and moral stances. The courts have had to distinguish between euthanasia, anti-dysthanasia, suicide and state assisted suicide. Potential liabilities of doctors, guardians, friends and family required close scrutiny in terms of both their recognized and implied responsibilities. Citizen's rights and state interests need to be considered and balanced.

The scope of this analysis will focus on judicial authority to act and how this authority is applied when faced with a right to die situation. This authority and its application forms the precedent and policy germane to the issue of euthanasia as we define it here.

An examination of the judicial decisions and issues relevant to the right to die subject therefore requires a multi-faceted approach. Since there are no Federal statutes and few strictly construed interpretations of the Federal Constitution mandating nationwide compliance to a particular course of conduct, states have been free to determine their own particular standards and apply those standards as they have deemed most appropriately for their citizens.

As a result, individual states have promulgated separate right to die legislation, guardianship statutes and/or living will legislation. The courts, however, have taken a proactive stance in the

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analysis of these statutes and have gone to great lengths, not only to provide interpretation of legislative intent, but, to add non-legislative rationalization of the issues, thereby providing greater justification for their decisions.

Despite the fact that the Florida Life-Prolonging Procedure Act stated that it was cumulative with existing law, the Florida District Court of Appeal, when faced with a situation not specifically addressed by the statute, held that the statute "was not intended to encompass the entire spectrum of instances in which these privacy rights may be exercised (Corbett v. D'Alessandro, 487 So.2d 368, Fla. Dist. Ct. App. 1986). The privacy right referred to is a constitutional privacy right to be later discussed below.

The Delaware Supreme Court, affirming a Delaware Chancery Court decision, held that "the General Assembly did not intend the Death With Dignity Act to be the exclusive method for deciding whether to withhold or withdraw medical treatment and life support from an incompetent person" (In the Matter of Charlotte F. Tavel, No. 225, De. Supr. Ct. 1995).

In 1993, in Deqrella v. Elston (No.92-SC-756-TG, Ky. Supr. Ct. July 15, 1993), it was argued that the Kentucky Living Will Act and the Health Care Surrogate Act excluded nutrition and feeding tubes in defining those treatments that might be withheld. The Kentucky Supreme Court however, allowing the removal of nutrition and feeding tubes, determined that the Acts in question merely supplemented the common law and were not meant to be solely interpreted and all encompassing.

Judicial authority to order or allow the discontinuance of life support measures by the courts has been recognized in every state and federal jurisdiction (Annot., 48 A.L.R.4th 67). The theory behind this authority, however, varies by jurisdiction and many states recognize that multiple theories should be considered (In Re Torres, 357 N.W.2d 332, Minn. 1984; Foody v. Manchester Memorial Hospital, 40 Conn. Sup. 127, 482 A.2d 713,1984).

While each individual case presents its own particular and often unique fact pattern, a number of common issues must be recognized and construed. These issues include the following:

1. Patient's rights must be weighed against the rights of the state.

2. Competency versus non-competency of the patient must be determined.

3. Statutes must be interpreted and applied.

4. When dealing with incompetent patients, acceptable decision making theories and their applications must be determined.

5. Variable factors such as age, condition and location must be weighed.

6. Patient's wishes, whether stated or implied, must be considered.

7. Liability, if any, of doctors, hospital nursing homes, family, guardians and/or other decision makers must be resolved.

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8. Necessity of judicial review must be determined and stipulated.

From the onset of this portion of this study, it is noteworthy to recognize and applaud the state courts throughout the nation for their thoughtful and often difficult dedication to their task. More often than not, the party in question had either died prior to the hearing of the lawsuit or died during the suit itself. While it would have been simple to declare such contentious matters moot, thereby easily sidestepping the controversy, they took it upon themselves to accept the challenge and create necessary policy.

A court will hear a case that is otherwise moot where two factors can be proven. It must be shown that a similar fact situation is likely to present itself before the courts on another occasion, and the court must be convinced that the matter is likely to evade review if the current case is not heard (In Re Lawrence, 579 N.E. 2nd 32, Ind. Sup. Ct. 1991; In Re Joelle Rosebush, 195 Mich. App. 675, 491 N.W.2d 633, 1992).

2. PATIENTS' RIGHTS

Patients, whether competent or incompetent, are afforded variety of rights as interpreted and applied by their states. These rights include the right to privacy as interpreted from the Federal and state constitutions, the common law rights to be free of bodily invasions, self determination and informed consent. Many states have grounded their decisions in both constitutional and common law analysis, thereby holding that the same right might stem from multiple theories.

There has been only one "right to die" case heard before the Supreme Court of the United States. In that case, the court skirted the issue of whether a constitutional right to privacy is directly found in the Federal Constitution. While they did not reject the theory outright, they failed to find a constitutional right of privacy and instead couched the issue in terms of Fourteenth Amendment liberty interest. This was the same approach taken by the Supreme Court in Roe v. Wade (410 U.S. 113, 1973). Chief Justice Rehnquist, delivering the majority opinion, held that "for 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" (Cruzan v. Director, Missouri Dept of Health, 110 S.Ct 2841, 1990).

By "assuming" rather than "holding," one must wonder if America's top court is leaving a means to change their mind in the future. The state courts, however, have had no difficulty in holding that the right to privacy is a firmly entrenched constitutional liberty.

The Pennsylvania Supreme Court recently held that there is no longer any question that the United States Constitution provides protection for an individual's right of privacy. At least two distinct types of privacy interests have been recognized. One is the individual interest in avoiding disclosure of personal matters, and the other is the interest in independence in making certain kinds of important decisions (In Re Fiori, 652 Ao 2d 135, 1995; quoting, Stenger v. Lehigh Valley Hospital Center, 530 Pa. 426, 609 A.2d 796, 1992).

The California Court of Appeal held that the constitutional right of privacy "guarantees to the individual the freedom to choose to reject, or to consent to, intrusions of his bodily integrity."

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The court further held that, "the right of a competent adult to refuse medical treatment is a constitutionally guaranteed right which must not be abridged" (Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220, Ct. App. 1984).

In Superintendent of Belchertown State School v. Saikewicz (373 Mass.728, 370 N.E.2d 417, 1977), the Massachusetts Supreme Judicial Court ruled that "The constitutional right to privacy 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 competent human being the right of choice."

Many other states have chosen similar theories of constitutional interpretation with regard to the application of the right to privacy. States have found the privacy right to arise from state constitutions as well as interpretations of the First, Third, Fourth, Fifth and Ninth Amendments of the Federal Constitution.

Only one state has rejected the theory that the right to privacy can be found in the Federal Constitution. The Missouri Supreme Court held in Cruzan v. Harmon (760 S.W.2d 408, Mo. Supr. Ct. 1989) that there was no constitutional basis for right to privacy and opined that they had "grave doubts" about the applicability of such doctrine. They recognized that other state decisions have relied upon this theory and noted that these were often "bare statements... seldom supported by reasoned analysis." The Cruzan state court did however accept the principle that citizens do enjoy common law rights that they could exercise or have exercised for them. These rights embrace such concepts as self determination, freedom from bodily invasions, and informed consent.

In a California case, Thor v. Superior Court (5 Cal. 4th 725, 21 Cal. Rptr.2d 357, 855 P.2d 375, Supr. Ct. 1993), the latter court expanded upon the previously accepted constitutional right of privacy by noting that "A competent, informed adult has a fundamental right of self determination to refuse or demand the withdrawal of medical treatment of any form irrespective of the personal consequences." That court went on to say that it did not matter whether the choice was medically or personally prudent. The common law right was just too important.

The Delaware Supreme Court in, In The Matter of Charlotte F. Tavel, citing both constitutional and common law rights, relied upon Union Pac. Ry. Co. v. Botsford (141 U.S. 250,1891) and quoted the Supreme Court of the United States, which wrote 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 [or her] own person, free from all constraints or interference of others unless by clear and unquestionable authority of law." The aforementioned court then went on to say that "The preservation of that common law right of self determination has been implemented by the Fifth Amendment to the United States Constitution." They further ruled that "A competent person's constitutional right to self determination cannot be eliminated by statute", and that, "the right of self determination is not lost when an individual becomes incompetent." [See also: In Re Jobes, 108 N.J. 394, 529 A.2d 434, Supr. Ct. 1987 ; Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677, App. Div. 2nd Dept 1987.]

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The concept put forth in Union Pacific Ry. Co., was the basis for Schloendorff v. Society of New York Hospital (211 N.Y. 125, 105 N.E. 92 , App. Ct. 1914), in which Justice Cardozo wrote, “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 patients consent commits an assault, for which he is liable in damages.” Citing Schloendorff, Justice Rehnquist in Cruzan stated that, "The informed consent doctrine has become firmly entrenched in American tort law." He further declared that, "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."

Informed consent--interpreted as the right not to consent, the right to self determination and the right to be free from bodily intrusions--has been universally recognized. Whether construed alone, or in conjunction with constitutional privacy interpretations, these are powerful rights afforded citizens.

3. STATES’ INTERESTS

No court in the United States has failed to recognize the common law rights of their citizens. Whether they look to self determination, freedom from bodily intrusions, or the doctrine of informed consent, the result is essentially the same: an authoritative right of choice can rarely be denied or abridged.

No rights however, are entirely absolute. While the courts must, and do, give enormous weight to common law rights as well as constitutional liberties, states are still mandated to weigh each right against four traditional state interests. Courts identify these state interests as: (1) preservation of life; (2) prevention of suicide; (3) protection of innocent third parties: and (4) maintaining the ethical integrity of the medical profession.

The interest in preventing suicides has been widely addressed. The New Jersey case of In Re Conroy (98 N.J.321, 486 A.2d 1209, Supr. Ct. 1985) involved a woman who was being fed through a feeding tube because she could not swallow. The court rejected the suicide argument, determining that it was the patient's wish to be free from invasive medical care and that upon the removal of the feeding tube, the cause of death would be the underlying disease and resulting inability to swallow.

The Nevada Court in McKay, supra, reasoned that the patient, in requesting the removal of his ventilator, was not committing suicide but instead was merely allowing the disease to take its natural course. In essence, the latter court reasoned that the removal was not the instrument of death but instead the disease was. Hector Rodas suffered permanent brain damage from drug abuse and was left permanently paralyzed from the neck down and in constant pain. Although he could not speak, he was able to communicate by blinking his eyes. He requested that his tube feeding be discontinued and the hospital refused, claiming that to do so they would be assisting in a suicide. The court emphatically denied the hospital’s position, asserting that, "Suicide does not occur where the natural consequences of a person's illness is death” (Nl Re Rodas, supra).

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Along with New Jersey, Nevada and Colorado, this line of reasoning has been followed by a number of states. No state, in fact, has ruled the removal of life support to be suicide. Maintaining the ethics of the medical profession has also been regularly deliberated.

The Pennsylvania Medical Society, filing an amicus curiae brief in In Re Fiori, supra, quoted the AMA Council on Ethical and Judicial Affairs: "...medical ethical principles support the withdrawal of life sustaining treatment, including the provision of nutrition and fluids, when, as here, there is no hope of recovery and the decision is made by an obviously concerned and well-informed surrogate decision maker exercising a choice based on the patient's preferences when they can be discerned or, if they cannot be determined, based on the patients best interests."

The Arizona Supreme Court, in Rasmussen v. Fleming (154 Ariz. 207, 741 P.2d 674 ,1987), cited the same AMA statement: "Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment" (AMA Council, Id.).

A similar stance has been taken by every state court. A discussion of civil and criminal liability with regard to physicians and medical care facilities follows below.

The state's interest in preserving life, particularly in the case of a competent adult, will also rarely be persuasive enough to overturn the wishes of a patient. "With few exceptions, the competent patient's informed desires will prevail in a test against the state interests. In cases that do not involve the protection of the actual or potential life of someone other than the decision maker, the state's indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of his own life...On balance, the right to self determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death" (In Re Conroy, 98 N.J.321, 486 A.2d 1209, Supr. Ct. 1985).

Daniel Delio, 33 years old and a marathon runner, suffered cardiac arrest during surgery. He was left in a vegetative state and needed two artificial feeding tubes to function. The New York Court, after weighing the state's interest in preserving life, held that "Clearly, there is no benefit to the State in prolonging Daniel's existence under circumstances he would have found demeaning and degrading to his humanity and which would serve merely to lessen the value of his life by denying him the right to choose the course of his medical treatment" (Delio v. Westchester County Medical Center, supra).

The Delaware Supreme Court determined that treatment could be withheld from a child with cancer who was given only a 40% chance to survive by his doctors. Although the child and his parents opposed the treatment on religious grounds as Christian Scientists, the court made its decision not on the constitutional basis of freedom of religion but instead on common law rights. After weighing risk to success factors, the court announced that in the face of "long odds" the state interest in preserving life will diminish where the treatment is more likely to fail than to succeed (Newmark v. Williams, 588 A.2d 1108, Del. Supr. Ct. 1991).

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In the absence of special circumstances, no state has imposed their interest upon a patient exercising their constitutional or common law rights. Where they have imposed their interest is in conjunction with the state's interest in protecting third parties.

In United States v. George (239 F. Supp. 752, D.C. Conn. 1965), a father with four (4) dependant children was denied the right to refuse a transfusion needed to save his life. The children, because of their age and situation, were determined to be appropriate citizens who the state was required to protect.

The Florida Appellate Court determined in M.N. v. Southern Baptist Hosp, of Florida, Inc. (648 So.2d 769, Fla. App. 1st District 1994), that the state may override the parent-child relationship where there is a compelling state interest. In State ex. rel. Schuetzle v. Vogel (537 N.W. 2d 888, (N.D. Supr. Ct. 1995), a prisoner refused to take his needed insulin. Recognizing that a competent person may refuse medical treatment, the court looked to the reason for Vogel's actions and determined that they were solely to manipulate the system (he was seeking a transfer) and determined that the state's interest in preserving order and reducing unrest--thereby protecting third parties--must prevail. Similarly, the Florida Supreme Court recognized a prisoner's constitutional right to starve himself, but likewise determined that the state's interest must overcome the individual's right when protecting the prisoner's minor dependent children (Singletary v. Costello, 665 So.2d 1099, Fla. Supr. Ct. 1996).

4. STANDARDS OF EVIDENCE

Before the balancing of the patient rights and state interests can be effectively accomplished, one of the significant factors that must be resolved is what the patient's true desires are. When the patient is competent, there is obviously no problem in determining their wishes. Once determined, they will be respected and carried out in the absence of a prevailing state interest. "On balance, the right to self determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death" (Cruzan v. Director, Missouri Department of Health, supra, quoting In Re Quinlan, supra). In her concurring opinion, U.S. Supreme Court Justice O'Connor wrote that "Artificial feeding cannot readily be distinguished from other forms of medical treatment... A [feeding tube]... must be surgically implanted in the stomach or small intestine...Requiring a competent adult to endure such procedures against her will burden the patient's liberty, dignity and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water."

If a patient is incompetent, it must be determined whether or not he or she had ever been competent, and if so, whether they had expressed their feelings while competent. Naturally, the most difficult task that the court faces is determining a patient's course of treatment where they had never been competent. There is no doubt that the courts have agreed that the incompetent person should be afforded the same rights as the competent person. This concept has been embraced by state courts as well as the Supreme Court of the United States: "An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to

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refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate" (Cruzan v Director, Missouri Department of Health, supra).

Where the states differ however, is in the standard that the surrogate must use when applying the incompetents rights and whether or not the courts must be actively involved. State courts have developed three measures: they will look to substituted judgment, best interests, and clear and convincing evidence tests.

When an incompetent person, prior to their incompetence, had clearly expressed a desire or made a decision regarding their medical care known, their wishes are respected: "In every case where a court has been asked to permit the withdrawal of life sustaining treatment from a patient in a persistent vegetative state, the court has held that if it can be definitely determined that it would have been the patient's desire not to receive such treatment, then the patient's right to self determination outweighs any state interest and the treatment may be withdrawn...Thus the right to self-determination has uniformly been held to survive incompetency and if the patient's own desires can be ascertained, the right outweighs any state interest, including the preservation of life" (In Re Fiori, supra).

Since the removal of life-sustaining systems ultimately results in death, all states obviously prefer that the patient express their thought and wishes conclusively in writing. Unfortunately, this is not the usual case. Without written instructions, the courts must rely on evidence that can be adduced from family and friends. Family members, in consultation with doctors, have always been deemed to be the best and most appropriate surrogates with regard to carrying out the wishes of the patient. Since the formality of a written statement is relatively infrequent and many people were perhaps unclear or not extremely specific in conversations, the great majority of states authorize family members to exercise substituted judgment. "Under the substituted judgment doctrine, where an incompetent's wishes are not clearly expressed, a surrogate decision maker considers the patient's personal value system for guidance. The surrogate considers the patient's prior statements about and reaction to medical issues, all the facets of the patient's personality that the surrogate is familiar with--with of course, particular reference to his or her relevant philosophical, theological and ethical values in order to extrapolate what course of medical treatment the patient would choose" (In Re Jobes, supra).

A minority of state courts take extra precautions in analyzing the situation and apply the clear and convincing evidence rule. "The clear and convincing evidence standard is an intermediate evidentiary standard, higher than mere preponderance, but lower than proof beyond a reasonable doubt" (In the Matter of Charlotte F. Tavel, supra, quoting In Re Rowe, 566 A.2d 1001, Del. Jud. 1989). Essentially, the court must be convinced that the patient's wishes were exactly and specifically made, and should the court be less than certain, it will prefer to err on the side of life and will deny any request for withdrawal of life support systems. Since the consequences of their decision are irrevocable, the courts at times reach somewhat implausible decisions when interpreting the clear and convincing standard.

Mary O'Connor was seventy-seven and due to a series of strokes, was rendered incompetent but conscious, requiring nourishment through a feeding tube due to her inability to swallow. Mary's

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two daughters and a long-time friend and co-worker testified that she had on numerous occasions commented that she did not wish to be maintained on life-prolonging apparatus should she ever become incompetent. They pointed out that she had attended to her husband and brothers during prolonged fatal illnesses and that she had worked in a hospital for twenty years. She had also reiterated her feelings after hospitalization for a heart attack. The court refused to give weight to her statements, claiming that they were, "immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death" (In Re Westchester County Medical Center, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607, App. Ct. 1988). The court further concluded that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will', while he or she was still competent."

Recognizing that the irreversibly comatose patient was entitled to enjoy the common law right of informed consent and refuse life sustaining treatment, and further recognizing that clearly stated wishes of a patient should be honored even if the once competent patient were now incompetent, the court, in In Re Martin (538 N.W.2d 399, Mich. Supr. Ct. 1995) still refused to allow a spouse to authorize the removal of life support equipment. Applying a clear and convincing standard, the court determined that despite at least six separate instances in which the patient had expressed a desire to eschew life support if irreversibly comatose, the statements were not convincing or compelling. That case appears to be a departure from previous Michigan decisions. Previously in Michigan, courts were directed to apply substituted judgment standards where there was any evidence of a patient's wishes and best interest principles where the patient had never expressed a desire. [See, In Re Joelle Rosebush, supra.]

Without endorsing or denouncing the clear and convincing evidence standard, the United States Supreme Court, after recognizing the differing tests used by various states, declared that it was the individual states' decision with regard to the standard of evidence required. They then affirmed the right of Missouri to require clear and convincing evidence (Cruzan v. Director, Missouri Department of Health, supra).

In those situations in which a once-competent party but now incompetent person had never expressed clear wishes, the states will follow either a substituted judgment rule or a best interests rule. If the patient is a minor or is an adult that had never been competent, state courts generally look to the best interests rule. Where the substituted judgment rule uses people familiar and close to the patient to act as the patient's representative, the best interests rule is much more subjective and less structured. It has been defined as the "course that will promote the patient's well-being as it would probably be conceived by any reasonable person in the patient's circumstances." Applied by a surrogate, the question is not what the patient would have wanted but instead what the average person would think best for the patient in terms of relieving suffering, preservation of life, and quality of life.

Several factors are generally considered in the decision making process. These will include the patient's extent of disability, age, life expectancy, pain and suffering, quality of continued life, religious beliefs, risks of continued care, family and physician opinions, prior statements made by the patient, further care required and overriding state interests (In Re Beth Israel Medical Center, supra).

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Occasionally, states will use a combination of tests in particular situations. New Jersey applies a best interest test in determining the issue of discontinuance of a never-competent patient's treatment while using a clear and convincing standard to determine the patient's condition. [See In Re Moorehouse, 250 N.J. Super. 307, 593 A.2d 1256, Super. Ct. 1991.] Connecticut has used both the substituted judgment and best interest tests simultaneously to arrive at a decision from two different perspectives (Foody v. Manchester Memorial Hospital, supra). State courts also sometimes purport to use one test while actually using another. The Delaware Supreme Court upheld the Delaware Chancery Court when it affirmed the Chancery ruling that, "The Court of Chancery held that Mrs. Tavel-Lipnick was required under the 'substituted judgment' standard to prove through clear and convincing evidence that her mother would have wanted the tube removed." If a state requires clear and convincing evidence, they are not really allowing for substituted judgment (In the Matter of Charlotte F. Tavel, supra; see also Degrella v. Elston, supra, and In Re Torres, supra).

By definition, substituted judgment cannot apply to never-competent patients. In essence, how can one substitute their judgment for someone else's where that other person was never lucid enough or capable enough to have formed judgment? Nevertheless, the Massachusetts courts have continued to apply the substituted judgment test in dealing with minor patients (In Re Care and Protection of Beth, supra) and retarded patients (In Re Guardianship of Jane Doe, 411 Mass 512, 583 N.E.2d 1263, Supr. Ct. 1992; Superintendent of Belchertown State School v. Saikewicz, supra).

One variation of generally accepted rules that does make sense is the "mature minor" rule followed in West Virginia. A patient was 17 years and 8 months old when he was admitted to the hospital; he had been confined to a wheelchair his whole life due to muscular dystrophy. When a question arose as to the course of his treatment, a further question arose as to whether he had the right to decide on continued treatment or discontinuance of treatment. In promulgating the mature minor rule, the court observed that "It is difficult to imagine that a young person who is under the age of majority, yet, who has undergone medical treatment for a permanent or recurring illness over the course of a long period of time, may not be capable of taking part in decisions concerning that treatment" (Belcher v. Charleston Area Medical Center, 188 W.Va. 105,422 S.E.2d 827, Supr. Ct. of App. 1992). The latter court further identified several factors that needed to be considered in determining the maturity of the minor. These included, age, experience, education, and the ability to comprehend and appreciate the risks and consequences of their decisions. In most cases, as long as the family and doctors agree that the patient had clearly expressed their desires, and the doctors determine that the patient's condition is irreversible, no further proceedings are required. Such reasoning will apply even if the patient is incompetent where family members and doctors agree that the substituted judgment or best interests of a patient clearly indicate a discontinuance of treatment. Most states have determined that such decisions are not required to come before the courts and should be made privately.

Naturally, where there is a dispute amongst interested parties' special situations, the courts remain available to resolve these issues. Interested parties have been identified as family, close friends, treating physicians, and health care ethics committees, but do not include public interest

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groups. Special situations include minority age status, state guardianship in the absence of family, and the presence of compelling state interests. Many of the early cases resulted from physicians and health care facilities seeking guidance from the courts and immunity from civil and criminal prosecution. It is only natural that the divergence from a doctor's quest to preserve life, in combination with today's litigious society, mandated that physicians protect themselves. Certainly, should a doctor treat a patient against the patient's wishes, they will be held liable (In Re Rodas, supra; Schloendorff v. Society of New York Hospital, supra), and doctors may not substitute their own judgment without consulting available family (Veldez v. Bethune, 219 Ga. App. 679, 446 S.E.2d 627, Ct. App. 1994). Most state courts have determined that doctors and health care facilities will have no liability--either civil or criminal--even in the absence of advance judicial authorization, while a few states do require prior judicial authorization.

A final question arises when the actual removal of life support is appropriate and at hand. While a doctor or health care facility will not be held liable for discontinuing treatment, can they be forced to participate against their wishes? The courts seem to make every attempt to reach a compromise. Where a patient can be transferred to another facility, the courts will permit the transfer if it does not adversely impact the patient. [See Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E.2d 626, Supr. Ct. 1986.] Courts have also implied that if the facility's policy is made known to the patient (or family) prior to admittance, this will be given great weight in determining whether the facility must comply with discontinuance of life support against their stated policy. [See In Re Jobes, supra; In Re Requena, 213 N.J. Super. 475, 517 A.2d 886, Super. Ct. Ch. Div. 1986; Elbaum v. Grace Plaza of Great Neck, 148 A.D.2d 244, 544 N.Y.S.2d 840, Supr. Ct. App. Div. 1989; In Re Rodas, supra.] However, the patient's rights, just as they typically overrule state interests, will supplant the rights of the hospital where no transfer is available and/or if the patient would suffer unnecessarily due to the hospital's attempted adherence to their policy. [See; Brophy v. New England Sinai Hospital, supra; In_Re_Jobes, supra; In Re Requena, supra; Elbaum v. Grace Plaza of Great Neck, supra; In Re Rodas, supra].

5. DISCUSSION

The continuing controversy associated with assisted suicide cases--particularly those performed by Dr. Jack Kevorkian in the 1990s--remains at the forefront of public consciousness in the United States. Yet, the right to die area has ramifications for the American medical establishment, government, and citizenry. This essay has focused on legal and constitutional thought, together with case decisions pertaining to euthanasia, over two decades. It has revealed the complexity of interpretation, categories of concern, and patterns of action from a judicial standpoint. Such an orientation should be integrated with ethical and public policy perspectives in order to fully comprehend the development, present status, and prospective impact of the right to die topic. This will be our objective in future research on the subject presented herein.

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