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

Summary (Facts)

Karen Ann Quinlan, a twenty-two-year-old who ingested a harmful mix of drugs and alcohol, suffered two fifteen-minute periods of interrupted breathing which left her in a chronic vegetative state without any cognitive functions.

Evidence in the case included statements the patient made earlier referring to her "distaste for continuance of life by extraordinary medical procedures." These statements were deemed by the court as remote, impersonal and lacking trial "probative weight."

Mr. Cruzan, the patient's father, sought appointment as her guardian along with the authority to terminate "all extraordinary medical procedures." This petition was opposed by the doctors, the hospital, the prosecutor, and the guardian ad litem.

The trial court refused the order to withdraw life-supporting apparatus. The father/guardian appealed.

Holding

The State's interest to maintain life weaken, and a patient's right of privacy grows, as the degree of bodily invasion increases and as prognosis dims.

Notwithstanding an acceleration of death, no criminal homicide results, and no civil liability would follow. However, because of the lapse of intervening time, a more current assessment of the prognosis was needed if the prognosis of the then-attending physician was unchanged (and it being contemplated that the guardian would employ different physicians). The new physician should seek concurrence of the ethics committee, the guardian, and the patient's family.

70 N.J. 10

In the Matter of Karen Quinlan, An Alleged Incompetent. Supreme Court of New Jersey. Argued Jan. 26, 1976. Decided March 31, 1976. (abridged)

Resume

The father, Mr. Quinlan, sought to be appointed guardian of person and property of his twenty-one year-old daughter who was in a persistent vegetative state and sought the express power of authorizing the discontinuance of all extraordinary procedures for sustaining his daughter's vital processes. The superior Court...denied authorization for termination of the life-supporting apparatus and withheld letters of guardianship over the person of the incompetent. The father appealed and the Attorney General cross-appealed. The Supreme Court, Hughes, C.J., held that a decision by the daughter to permit a noncognitive, vegetative existence to terminate by natural forces was a valuable incident of her right to privacy which could be asserted on her

behalf by her guardian; that the state of the pertinent medical standards and practices which guided the attending physicians who held the opinion that removal from the respirator would not conform to medical practices, standards and traditions was not such as would justify the court in deeming itself bound or controlled thereby in responding to case for declaratory relief; and that upon the concurrence of guardian and family, should the attending physicians conclude that there was no reasonable possibility of the daughter's ever emerging from her comatose condition to a cognitive, sapient state and that the life-support apparatus should be discontinued, physicians should consult with hospital ethics committee and if the committee should agree with the physicians' prognosis, the life-support systems may be withdrawn and said action shall be without any civil or criminal liability, therefore, on the part of any participant, whether guardian, physician, hospital or others.

Modified and remanded.

The opinion of the Court was delivered by HUGHES, C.J.

The Litigation

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

The issues are before this Court following its direct certification of the action under the rule, R.2:12-1, prior to hearing in the Superior Court, Appellate Division, to which the appellant (hereafter "plaintiff') Joseph Quinlan, Karen's father, had appealed the adverse judgment of the Chancery Division.

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

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

The Attorney General of New Jersey intervened as of right pursuant to R. 4:33-1 on behalf of the State of New Jersey, such intervention being recognized by the court in the pretrial conference order (R. 4:25-1 et seq.) of September 22, 1975. Its basis, of course, was the interest of the State in the preservation of life, which has an undoubted constitutional foundation.

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

The Factual Base

An understanding of the issues in their basic perspective suggests a brief review of the factual base developed in the testimony and documented in greater detail in the opinion of the trial judge.

On the night of Aprill5, 1975, for reasons still unclear, Karen Quinlan ceased breathing for at least two 15-minute periods. She received some ineffectual mouth-to-mouth resuscitation from friends. She was taken by ambulance to Newton Memorial Hospital. There she had a temperature of 100 degrees, her pupils were unreactive, and she was unresponsive even to deep pain. The history at the time of her admission to that hospital was essentially incomplete and uninformative.

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

occurring within three to four weeks. In the awake cycle she blinked, cried out and did things of that sort but was still totally unaware of anyone or anything around her.

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

Dr. Morse, as well as the several other medical and neurological experts who testified in this case, believed with certainty that Karen Quinlan is not "brain dead." They identified the Ad Hoc Commit tee of Harvard Medical School report as the ordinary medical standard for determining criteria specified in that report and was therefore not "brain dead" within its contemplation.

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

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

Because Karen's neurological condition affects her respiratory ability (the respiratory system being a brain stem function) she requires a respirator to assist her breathing. From the time of her admission to Saint Clare's Hospital Karen has been assisted by an MA-l respirator, a sophisticated machine which delivers a given volume of air at a certain rate and periodically provides a "sigh" volume, a relatively large measured volume of air designed to purge the lungs of excretions. Attempts to "wean" her from the respirator were unsuccessful and have been abandoned.

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

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

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

of her feeling impulses is unknown. She grimaces, makes stereotyped cries and sounds and has chewing motions. Her blood pressure is normal.

Karen remains in the intensive care unit at Saint Clare's Hospital, receiving 24-hour care by a team of four nurses characterized, as was the medical attention, as "excellent" She is nourished by feeding by way of a nasal-gastro tube and is routinely examined for infection, which under these circumstances is a serious life threat. The result is that her condition is considered remarkable under the unhappy circumstances involved.

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

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

She is debilitated and moribund and although fairly stable at the time of argument before us (no new information having been filed in the meanwhile in expansion of the record), no physician risked the opinion that she could live more than a year and indeed she may die much earlier. Excellent medical and nursing care so far has been able to ward off the constant threat of infection, to which she is peculiarly susceptible because of the respirator, the tracheal tube and other incidents of care in her vulnerable condition. Her life accordingly is sustained by the respirator and tubal feeding, and removal from the respirator would cause her death soon, although the time cannot be stated with more precision.

The determination of the fact and time of death in past years of medical science was keyed to the action of the heart and blood circulation, in turn dependent upon pulmonary activity, and hence cessation of these functions spelled out the reality of death.

Developments in medical technology have obfuscated the use of the traditional definition of death.

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

From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes so the obvious criterion of no heartbeat as synonymous with death was sufficiently accurate. In those times the heart was considered to be the central organ of the body it is not surprising that its failure marked the onset of death. This is no longer valid when modem resuscitative and supportive measures are used. These improved

activities can now restore "life" as judged by the ancient standards of persistent respiration and continuing heartbeat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain damage...

The Ad Hoc standards, carefully delineated, included absence of response to pain or other stimuli, pupillary reflexes, corneal, pharyngeal and other reflexes, blood pressure, spontaneous respiration, as well as "flat" or isoelectric electroencephalograms and the like, with all tests repeated "at least twenty-four hours later with no change." In such circumstances, where all of such criteria have been met as showing brain death," the Committee recommends with regard to the respirator:

The patient's condition can be determined only by a physician. When the patient is hopelessly damaged as defined above, the family and all colleagues who have participated in major decisions concerning the patient, and all nurses involved, should be so informed. Death is to be declared and then the respirator turned off. The decision to do this and the responsibility for it are to be taken by the physician-in-charge in consultation with one or more physicians who have been directly involved in the case. It is unsound and undesirable to force the family to make the decision...

But, as indicated, it was the consensus of medical testimony in the instant case that Karen, for all her disability; met none of these criteria, nor indeed any comparable criteria extant in the medical world and representing, as does the Ad Hoc Committee report, according to the testimony in this case, prevailing and accepted medical standards.

We have adverted to the "brain death" concept and Karen's disassociation with any of its criteria, to emphasize the basis of the medical decision made by Dr. Morse. When plaintiff and his family, finally reconciled to the certainty of Karen's impending death, requested the withdrawal of life support mechanisms, he demurred. His refusal was based upon his conception of medical standards, practice and ethics described in the medical testimony, such as in the evidence given by another neurologist, Dr. Sidney Diamond, a witness for the State. Dr. Diamond asserted that no physician would have failed to provide respirator support at the outset, and none would interrupt its life-saving course thereafter, except in the case of cerebral death. In the latter case, he thought the respirator would in effect be disconnected from one already dead, entitling the physician under medical standards and, he thought, legal concepts, to terminate the supportive measures. We note Dr. Diamond's distinction of major surgical or transfusion procedures in a terminal case not involving cerebral death, such as here.

The subject has lost human qualities. It would. be incredible, and I think unlikely, that any physician would respond to a sudden hemorrhage, massive hemorrhage or a loss of all her defensive blood cells, by giving her large quantities of blood. I think that...major surgical procedures would be out of the question even if they were known to be essential for continued physical existence.

This distinction is adverted to also in the testimony of Dr. Julius Korein, a neurologist called by plaintiff. Dr. Korein described a medical practice concept of "judicious neglect" under which the physician will say:

Don't treat this patient anymore...it does not serve either the patient, the family, or society in any meaningful way to continue treatment with this patient.

Dr. Korein also told of the unwritten and unspoken standard of medical practice implied in the foreboding initials DNR (do not resuscitate), as applied to the extraordinary terminal case:

Cancer, metastatic cancer, involving the lungs, the liver, the brain, multiple involvements, the physician may or may not write: Do not resuscitate... It would be said to the nurse: if this man stops breathing don't resuscitate him...No physician that I know personally is going to try to resuscitate a man riddled with cancer and in agony and he stops breathing. They are not going to put him on a respirator... I think that would be the height of misuse of technology.

While the thread of logic in such distinctions may be elusive to the non-medical lay mind, in relation to the supposed imperative to sustain life at all costs, they nevertheless relate to medical decisions, such as the decision of Dr. Morse in the present case. We agree with the trial court that the decision was in accord with Dr. Morse's conception of medical standards and practice.

Guardianship

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

To confirm the moral rightness of the decision he was about to make he consulted with his parish priest and later with the Catholic chaplain of Saint Clare's Hospital. He would not, he testified, have sought termination if that act were to be morally wrong or in conflict with the tenets of the religion he so profoundly respects. He was disabused of doubt, however, when the position of the Roman Catholic Church was made known to him as it is reflected in the record in this case. While it is not usual for matters of religious dogma or concepts to enter a civil litigation (except as they may bear upon constitutional right, or sometimes, familial matters; cf *In re Adoption of E*, 59 N.J. 36, 279 A 2d 785 (1971), they were rightly admitted in evidence here. The judge was bound to measure the character and motivations in all respects of Joseph Quinlan as prospective guardian; and insofar as these religious matters bore upon them, they were properly scrutinized and considered by the court.

Thus germane, we note the position of that Church as illuminated by the record before tis. We have no reason to believe that it would be at all discordant with the whole of Judea-Christian

tradition, considering its central respect and reverence for the sanctity of human life. It was in this sense of relevance that we admitted as amicus curiae the New Jersey Catholic Conference, essentially the spokesman for the various Catholic bishops of New Jersey, organized to give witness to spiritual values in public affairs in the statewide community. The position statement of Bishop Lawrence B. Casey, reproduced in the amicus brief, projects these views:

(a) The verification of the fact of death in a particular case cannot be deduced from any religious or moral principle and, under this aspect, does not fall within the competence of the church; that dependence must be had upon traditional and medical standards, and by these standards Karen Ann Quinlan is assumed to be alive.

(b) The request of plaintiff for authority to terminate a medical procedure characterized as “an extraordinary means of treatment" would not involve euthanasia. This upon the reasoning expressed by Pope Pius Xll in his "allocutio" (address) to anesthesiologists on November 24, 1957, when he dealt with the question:

Does the anesthesiologist have the right, or is he bound, in all cases of deep unconsciousness, even in those that are completely hopeless in the opinion of the competent doctor, to use modem artificial respiration apparatus, even against the will of the family?

His answer made the following points:

1. In ordinary cases the doctor has the right to act in this manner but is not bound to do so unless this is the only way of fulfilling another certain moral duty.

2. The doctor, however, has no right independent of the patient. He can act only if the patient explicitly or implicitly, directly or indirectly, gives him the permission.

3. The treatment as described in the question constitutes extraordinary means of preserving life and so there is no obligation to use them nor to give the doctor permission to use them.

4. The rights and the duties of the family depend on the presumed will of the unconscious patient if he or she is of legal age, and the family, too, is bound to use only ordinary means.

5. This case is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life, and we must apply in this case the principle of double effect.

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

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

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

The right to a natural death is one outstanding area in which the disciplines of theology, medicine and law overlap; or, to put it another way, it is an area in which these three disciplines convene.

Medicine with its combination of advanced technology and professional ethics is both able and inclined to prolong biological life. Law with its felt obligation to protect the life and freedom of the individual seeks to assure each person's right to live out his human life until its natural and inevitable conclusion. Theology with its acknowledgment of man's dissatisfaction with biological life as the ultimate source of joy...defends the sacredness of human life and defends it from all direct attacks.

These disciplines do not conflict with one another but are necessarily conjoined in the application of their principles in a particular instance such as that of Karen Ann Quinlan. Each must in some way acknowledge the other without denying its own competence. The civil law is not expected to assert a belief in eternal life; nor, on the other hand, is it expected to ignore the right of the individual to profess it, and to form and pursue his conscience in accord with that belief. Medical science is not authorized to directly cause natural death; nor, however, is it expected to prevent it when it is inevitable and all hope of a return to an even partial exercise of human life is irreparably lost. Religion is not expected to define biological death; nor, on its part, is it expected to relinquish its responsibility to assist man in the formation and pursuit of a correct conscience as to the acceptance of natural death when science has confirmed its inevitability beyond any hope other than that of preserving biological life in a merely vegetative state.

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

In the present public discussion of the case of Karen Ann Quinlan it has been brought out that responsible people involved in medical care, patients and families have exercised the freedom to terminate or withhold certain treatments as extraordinary means in cases judged to be terminal, i.e., cases which hold no realistic hope for some recovery, in accord with the expressed or implied intentions of the patients themselves. To whatever extent this has been happening it has been without sanction in civil law. Those involved in such actions, however, have ethical and theological literature to guide them in their judgments and actions. Furthermore, such actions have not in themselves undermined society's reverence for the lives of sick and dying people.

It is both possible and necessary for society to have laws and ethical standards which provide freedom for decisions, in accord with the expressed or implied intentions of the patient, to terminate or withhold extraordinary treatment in cases which are judged to be hopeless by competent medical authorities, without at the same time leaving an opening for euthanasia. Indeed, to accomplish this, it may simply be required that courts and legislative bodies recognize the present standards and practices of many people engaged in medical care who have been doing what the parents of Karen Ann Quinlan are requesting authorization to have done for this beloved daughter.

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

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

If is from this factual base that the Court confronts and responds to three basic issues:

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

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

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

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

Constitutional Legal Issues

The Right of Privacy

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

We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life support apparatus, even if it meant the prospect of natural death. To this extent we may distinguish Heston, supra, which concerned a severely injured young woman (Delores Heston), whose life depended on surgery and blood transfusion; and who was in such extreme shock that she was unable to express an informed choice (although the Court apparently considered the case as if the patient's own religious decision to resist transfusion were at stake), but most importantly a patient apparently salvable to long life and vibrant health; a situation not at all like the present case.

We have no hesitancy in deciding, in the instant diametrically opposite case, that no external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life. We perceive no thread of logic distinguishing between such a choice on Karen's part and a similar choice which, under the evidence in this case could be made by a competent patient terminally ill, riddled by cancer and suffering great pain; such a patient would not be resuscitated or put on a respirator in the example described by Dr. Korein, and a fortiori would not be kept against his will on a respirator.

Although the Constitution does not explicitly mention a right of privacy, Supreme Court decisions have recognized that a right of personal privacy exists and that certain areas of privacy are guaranteed under the Constitution. The Court has interdicted judicial intrusion into many aspects of personal decision, sometimes basing this restraint upon the conception of a limitation of judicial interest and responsibility, such as with regard to contraception and its relationship to family life and decision.

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

Nor is such right of privacy forgotten in the New Jersey Constitution ...

The claimed interests of the State in this case are essentially the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment. In this case the doctors say that removing Karen from the respirator will conflict with their professional judgment. The plaintiff answers that Karen's present treatment serves only a maintenance function; that the respirator cannot cure or improve her condition but at best can only prolong her inevitable slow deterioration and death; and that the interests of the patient, as seen by her surrogate, the guardian, must be evaluated by the court as predominant, even in the fact of an opinion contra by the present attending physicians. Plaintiff's distinction is significant the nature of Karen's care and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. We think that the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point .at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor she will never resume cognitive life. And the bodily invasion is very great-she requires twenty-four hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube.

Our affirmation of Karen's independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent, and we cannot discern her supposed choice based on the testimony of her previous conversations with

friends, where such testimony is without sufficient probative weight. Nevertheless, we have concluded that Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative, this decision should be accepted by a society the overwhelming majority of whose members would, we think: in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them. It is for this reason that we determine that Karen's right of privacy may be asserted in her behalf, in this respect, by her guardian and family under the particular circumstances presented in this record.

The Medical Factor

Having declared the substantive legal basis upon which plaintiff's rights as representative of Karen must be deemed predicated, we face and respond to the assertion on behalf of defendants that our premise unwarrantably offends prevailing medical standards. We thus tum to consideration of the medical decision supporting the determination made below, conscious of the paucity of pre-existing legislative and judicial guidance as to the rights and liabilities therein involved.

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

Perhaps the confusion there adverted to stems from mention by some courts of statutory or common law condemnation of suicide as demonstrating the state's interest in the preservation of life. We would see, however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death. The contrasting situations mentioned are analogous to those continually faced by the medical profession. When does the institution of life-sustaining procedures, ordinarily mandatory, become the subject of medical discretion in the context of administration to persons in extremis?

And when does the withdrawal of such procedures, from such persons already supported by them, come within the orbit of medical discretion? When does a determination as to either of the foregoing contingencies count the hazard of civil or criminal liability on the part of the physician or institution involved?

The existence and nature of the medical dilemma need hardly be discussed at length, portrayed as it is in the present case and complicated as it has recently come to be in view of the dramatic advance of medical technology. The dilemma is there, it is real, it is constantly resolved in accepted medical practice without attention in the courts, it pervades the issues in the very case we here examine. The branch of the dilemma involving the doctor's responsibility and the relationship of the count's duty was thus conceived by Judge Muir:

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

Such notions as to the distribution of responsibility, heretofore generally entertained, should however neither impede this Court in deciding matters clearly justifiable nor preclude a re-examination by the Court as to underlying human values and rights… Determinations as to these must, in the ultimate, be responsible not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the Court has a nondelegable judicial responsibility.

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

Courts in the exercise of their parents patriae responsibility to protect those under disability have sometimes implemented medical decisions and authorized their carrying out under the doctrine of "substituted judgment..." For as Judge Muir pointed out:

As part of the inherent power of equity, a Court of Equity has full and complete jurisdiction over the persons of those who labor under any legal disability. The court's action in such a case is not limited by any narrow bounds, but it is empowered to stretch forth its arm in whatever direction. its aid and protection may be needed. While this is indeed a special exercise of equity jurisdiction, it is beyond question that by virtue thereof the Court ·may pass upon purely personal rights...

But insofar as a court, having no inherent medical expertise, is called upon to overrule a professional decision made according to prevailing medical practice and standards, a different question is presented. As mentioned below, a doctor is required "to exercise in the treatment of his patient the degree of care, knowledge and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in his field. If he is a specialist, he "must employ not merely the skill of a general practitioner, but also that special degree of skill normally possessed by the average physician who devotes special study and attention to the

particular organ or disease or injury involved, having regard to the present state of scientific knowledge." This is the duty that establishes his legal obligations to his patients.

The medical obligation is related to standards and practice prevailing in the profession. The physicians in charge of the case, as noted above, declined to withdraw the respirator. That decision was consistent with the proofs below as to the then existing medical standards and practices.

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

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

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

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

The agitation of the medical community in the face of modem life prolongation technology and its search for definitive policy are demonstrated in the large volume of relevant professional commentary.

The wide debate thus reflected contrasts with the relative paucity of legislative and judicial guides and standards in the same field. The medical profession has sought to devise guidelines such as the "brain death" concept of the Harvard Ad Hoc Committee mentioned above. But it is perfectly apparent from the testimony we have quoted of Dr. Korein, and indeed so clear as almost to be judicially noticeable, that humane decisions against resuscitative or maintenance therapy are frequently a recognized de facto response in the medical world to the irreversible, terminal, pain ridden patient, especially with familial consent. And these cases, of course, are far short of "brain death."

We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable.

In this sense, as we were reminded by the testimony of Drs. Korein and Diamond, many of them have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such "therapy" offers neither human nor humane benefit. We think these attitudes represent a balanced implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the whole Judea-Christian tradition of regard for human life. No less would they seem consistent with the moral matrix of medicine, "to heal," very much in the sense of the endless mission of the law, "to do justice."

Yet this balance, we feel, is particularly difficult to perceive and apply in the context of the development by advanced technology of sophisticated and artificial life-sustaining devices. For those possibly curable, such devices are of great value, and, as ordinary medical procedures, are essential. Consequently, as pointed out by Dr. Diamond, they are necessary because of the ethic of medical practice. But in light of the situation in the present case (while the record here is somewhat hazy in distinguishing between "ordinary" and "extraordinary" measures), one would have to think that the use of the same respirator or life support could be considered "ordinary" in the context of the possibly durable patient but "extraordinary" in the context of the forced sustaining by cardiorespiratory processes of an irreversibly doomed patient. And this dilemma is sharpened in the face of the malpractice and criminal action threat which we have mentioned.

We would hesitate, in this imperfect world, to propose to physicians that type of immunity which from the early common law has surrounded judges and grand jurors...so that they might without fear of personal retaliation perform their judicial duties with independent objectivity. In Bradley v. Fisher...the Supreme Court held:

It is a general principle of the highest importance to the proper administration of justice that a judicial officer, in exercising the authority vested in him, shall be free to act upon his own convictions, without apprehension of personal consequences to himself. Lord Coke said of judges that "they are only to make an account to God and the King (the State)." Nevertheless, there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.

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

Dr. Teel recalls:

Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make. We are not always morally and legally authorized to make them. The physician is thereby assuming a civil and criminal liability that, as often as not, he does not even realize as a factor in his decision. There is little or no dialogue in this whole process. The physician assumes that his judgment is called for and, in good faith, he acts. Someone must and it has been the physician who has assumed the responsibility and the risk.

I suggest that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared. Many hospitals have established an ethics committee composed of physicians, social workers, attorneys, and theologians...which serves to preview the individual circumstances of ethical dilemma, and which has provided much in the way of assistance and safeguards for patients and their medical caretakers. Generally, the authority of these committees is primarily restricted to the hospital setting and their official status is more that of an advisory body than of an enforcing body.

The concept of an ethics committee which has this kind of organization and is readily accessible to those persons rendering medical care to patients, would be, I think, the most promising direction for further study at this point... [This would allow] some much needed dialogue regarding these issues and [force] the point of exploring all of the options for a particular patient. It diffuses the responsibility for making these judgments. Many physicians, in many circumstances, would welcome this sharing of responsibility. I believe that such an entity could lend itself well to an assumption of a legal status which would allow courses of action not now undertaken because of the concern for liability.

Alleged Criminal Liability

Having concluded that there is a right of privacy that might permit termination of treatment in the circumstances of this case, we turn to consider the relationship of the exercise of that right to the criminal law. We are aware that such termination of treatment would accelerate Karen's death. The County Prosecutor and the Attorney General maintain that there would be criminal liability for such acceleration. Under the statutes of this State, the unlawful killing of another human being is criminal homicide.... We conclude that there would be no criminal homicide in the circumstances of this case. We believe, first, that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.

These conclusions rest upon definitional and constitutional bases. The termination of treatment pursuant to the right of privacy is, within the limitations of this case ipso facto lawful. Thus, a death resulting from such an act would not come within the scope of the homicide statutes proscribing only the unlawful killing of another. There is a real and, in this case, determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination.

Furthermore, the exercise of a constitutional right such as we have here found is protected from criminal prosecution. We do not question the state's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy. The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime. And under the circumstances of this case, these same principles would apply to and negate a valid prosecution for attempted suicide were there still such a crime in this State.

The Guardianship of the Person

The trial judge bifurcated the guardianship, as we have noted, refusing to appoint Joseph Quinlan to be guardian to the person and limiting his guardianship to that of the property of his daughter. Such occasional division of guardianship, as between responsibility for the person and the property of an incompetent person, has roots deep in the common law and was well within the jurisdictional capacity of the trial judge.

The statute creates an initial presumption of entitlement to guardianship in the next of kin, for it provides:

In any case where a guardian is to be appointed, letters of guardianship shall be granted...to the next of kin, or if. . .it is proven to the court that no appointment from among them will be to the best interest of the incompetent or his estate, then to such other proper person as will accept the same. The trial court was apparently convinced of the high character of Joseph Quinlan and his general suitability as guardian under other circumstances, describing him as "very sincere, moral, ethical and religious." The court felt, however, that the obligation to concur in the medical care and treatment of his daughter would be a source of anguish to him and would distort his "decision-making processes." We disagree, for we sense from the whole record before us that while Mr. Quinlan feels a natural grief, and understandably sorrows because of the tragedy which has befallen his daughter, his strength of purpose and character far outweighs these sentiments and qualifies him eminently for guardianship of the person as well as the property of his daughter. Hence, we discern no valid reason to overrule the statutory intendment of preference to the next of kin.

Declaratory Relief

We thus arrive at the formulation of the declaratory relief which we have concluded is appropriate to this case. Some time has passed since Karen's physical and mental condition was described to the Court. At that time her continuing deterioration was plainly projected. Since the record has not been expanded, we assume that she is now even more fragile and nearer to death than she was then. Since her present treating physicians may give reconsideration to her present posture in the light of this opinion, and since we are transferring to the plaintiff as guardian the choice of the attending physician and therefore other physicians may be in charge of the case who may take a different view from that of the present attending physicians, we herewith declare the following affirmative relief on behalf of the plaintiff. Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or the body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others. We herewith specifically so hold.

Conclusion

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

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

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

We repeat for the sake of emphasis and clarity that upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life support system may be withdrawn and said action shall be without any civil or criminal liability therefore on the part of any participant, whether guardian, physician, hospital or others.

By the above ruling we do not intend to be understood as implying that a proceeding for judicial declaratory relief is necessarily required for the implementation of comparable decisions in the field of medical practice.

Modified and remanded.

For modification and remandment: Chief Justice HUGHES, Justices MOUNTAIN, SULLIVAN, PASHM:AN, CLIFFORD and SCHREIBER and Judge Conford-7.

Opposed: None.

QUINLAN: Discussion Questions

Questions for discussion: "70.N.J. 10. In the Matter of Karen Quinlan"

1. Did you notice the early use (in "The Litigation") of "extraordinary" to describe the medical procedures sustaining Karen's "vital processes and hence her life." Distinguish between "ordinary" and “extraordinary" means. What assumption/slay behind Justice Hughes' use of "vital processes"? Why didn't he simply say,"...sustaining Karen's life"?

2. In "The Factual Base," several important insights are made: the types of coma, the definition of "persistent vegetative state," the distinction between p.v.s. and "brain death," levels of brain stem function, the distinction between cardiovascular and brain death, etc. What is the basis for the physicians' unwillingness to remove the respirator from Karen? What ethical implications did such a removal have for them? (Note how the answers to these questions are based on assumptions and definitions that are not shared by the plaintiff.) This case shows how medical ethics differs from bioethics or clinical ethics. Do you see that difference?

3. The dilemma facing the judge (see "Guardianship") was to ascertain if Joseph Quinlan's request to remove ventilator support implied a disrespect for the value of human life. How did Quinlan's religious convictions assist the judge to resolve the dilemma? What role does religion often play in ethical decision-making?

4. The right of privacy ("Constitutional and Legal Issues") forms the basis for Justice Hughes' judgment concerning the legality of withdrawing the ventilator. How does he argue the right of privacy here?

   The conflict between the state's interest in preserving life vs. the individual right to privacy finds no absolute right in either arm of the dilemma Give instances where you believe the state's interest should prevail and where the individual's right should prevail.

   What is the significance of the following statement: "We think that the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." What is implied in this statement that bears on the priority ranking that values assume?

5. The right of physicians to follow prevailing medical standards ("The Medical Factor") necessitates the judge's reflection on "curing," "healing," and "doing justice." He emphasizes. that the decision whether or not to remove Karen's ventilator is not solely a medical decision but an ethical one as well, and to that end he makes mention of ethics committees, the first such formal reference made in a legal context. How is such a committee envisioned?

6. If termination of treatment would accelerate death, how can one justify such termination ("Alleged Criminal Liability")? What would be the "cause" of Karen's death?

7. How is guardianship defined ("The Guardianship of the Person")?

8. What conditions were placed on the withdrawing of the ventilator ("Declaratory Relief')?

9. How is the judge's view of ethics committee similar to and different from your own?

Further Readings

Rothman, David J. 1991. Strangers at the Bedside. Basic Books: 222-246.

Angell, Marcia. 1994. "After Quinlan: The Dilemma of the Persistent Vegetative State." NEJM 330 (May 26, 1994): 1524-5.

Brody, Baruch. 1992. "Special Ethical Issues in the Management of PVS Patients." Law Medicine and Health Care 20 (Spring-Summer): 104-115.

Multi-Society Task Force on PVS. 1994. "Medical Aspects of the Persistent Vegetative State." NEJM 330 (May 26 and June 2): 1499-1508.