Sourcebook on Death and Dying

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Consulting Editor
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Preface

In recent years professionals and laymen alike have begun to explore and deal with a wide range of topics associated with death and dying. Death with dignity, the philosophy and psychology of grief, legal and medical definitions of death and their implications, alternatives to the "traditional" funeral, and the outlook for increasing the human life span are just a few issues of concern today. The realities of death and dying can no longer be ignored until the moment of death. Legal and financial complexities, for example, make it advisable to prepare in advance of death; ethical questions are raised by institutions involved in the care of terminal patients and their families; technologies for prolonging life present dilemmas in law, medicine, theology and philosophy.

This sourcebook is for professionals, scholars, and others interested in issues, facts, figures, and sources of additional information about death and dying. Part I, Current Issues, presents article reprints covering views of professionals in related fields. The section deals with aspects of the right-to-die movement, including euthanasia, patients' rights, and living wills (documents through which individuals assert their right to a "good death" or "death with dignity"). Another important issue is the question of when a human being is truly dead. Legal and medical forces are struggling to set a standard, and the articles included on this topic present the arguments among proponents of various points of view.

Also discussed here is the relatively new field of bereavement counseling, which is approached not so much from a clinical point of view as from a professional vantage point which examines the parts played by various professionals in assisting grieving persons.

This section also contains articles dealing with American funeral practices, hospice and terminal care, estate planning, and anatomical gifts.

Part II, Facts and Figures, supports Part I with U.S. and Canadian statistics and other background data on the same and additional subjects pertaining to death and dying.

Sources of Information and Assistance, Part III, includes comprehensive listings, with addresses and other information, for death-related associations and societies, support/self-help groups for the bereaved and terminally ill, and institutions that are or contain facilities for terminally-ill patients. Both the United States and Canada are covered. This section concludes with an extensive publications list which contains both a collection of periodicals that regularly address issues in this field and a bibliography of books and audiovisual materials.

To make this sourcebook especially useful—and easy to use—we have provided a glossary of terms used by professionals in the field of death and dying.

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About the editor

James A. Fruehling, Ph.D. is Department Chairman, Department of Counselor Education, Northeastern Illinois University in Chicago. Dr. Fruehling is a registered psychologist and serves as a consultant for a number of organizations, including the National Selected Morticians.

Dr. Fruehling has written numerous articles on counseling, the role of the funeral director, and the professionalization of funeral service, and he regularly gives speeches and workshops on various aspects of death and dying.

PART 1

CURRENT ISSUES

In the Current Issues section of *Sourcebook on Death and Dying,* readers will find articles that present overviews on a number of special-interest topics. The editors chose these articles after reviewing various computer data bases representing journals (in law, psychology, sociology, medicine and finance), consumer-advocacy publications, and various professional newspapers. [*Note:* For most data bases, the articles chosen for review were published after 1976; for some, earlier articles were also examined.] From these bases, the editors evaluated approximately 1,500 English-language titles and abstracts representing both the United States and Canada.

The editors believe that their final selections will provide readers with a reasoned assessment of current issues—a solid base of up-to-date information on which to build.

THE RIGHT TO DIE— EUTHANASIA

Euthanasia: A Medical and Legal Overview

Howard N. Ward, M.D., J.D.

INTRODUCTION

The past decade has been a modern renaissance regarding the issues of death, dying, and euthanasia. Although many factors have no doubt contributed to this phenomenon, the following are deemed significant: 1) the flowering of modern scientific medicine with its technical ability to postpone the moment of death, 2) an alleged de-emphasis of compassion and a caring manner by physicians and nurses, and 3) the institutionalization of most dying patients in hospitals and nursing homes. In a primitive society, where medicine and science do not exist, man's natural right to die goes unchallenged. Hence, this rebirth of concern over a natural and inevitable process is both a reaction to medical progress as well as a recognition of the fact that until recently Americans have been using massive denial to avoid all contact with the realities of death and dying. Both the lay press and a variety of professional publications have been literally inundated with writings dedicated to the medical, legal, religious, social, ethical, emotional, and philosophical aspects of death, dying, and euthanasia. It will be the purpose of this paper to review these issues and where possible to offer suggestions that comport with modern man, his society and environment. Of course, it would be unmitigated arrogance to imply that one has the answers to such issues and no such intent is implied. But an opinion or suggestion based on experience and study is believed to be a meaningful place to start.

DEFINITION OF ISSUES AND PROBLEMS

In order to properly review euthanasia it is necessary to gain some understanding about death and dying in general. Firstly, death absent sudden causes such as trauma is a process and not an event. It is a natural and inevitable process. It is as natural as birth and indeed is the opposite end of the continuum. It is a biologically appropriate and necessary part of the regenerative cycle. If viewed in this context it is seen as no real threat but rather a normal part of the natural order of things within the framework of nature and God. Some have even given a euphemism to it by calling it the final stage of growth.[1] It can even be dealt with humorously, *e.g.*, death is nature's way of telling you to slow down. Although physicians have been accused of depersonalizing the process, there are many institutions in society which more accurately deserve such criticism, with perhaps the military being the epitome in signifying a death of a human being as a mere KIA (killed in action). Actually, dying is so intensely and inherently a personal matter that its real significance can perhaps only be appreciated by those actually engaged in it. Overcoming the denial of death, so pervasive in American culture, has undoubtedly been a necessary step in getting people to be more congenial with their personal mortality.

When analyzed as a process rather than a momentary event, it becomes self-evident that life itself is a spectrum with varying degrees of energy, vitality, self-awareness, self-control, memory, a sense of futurity, of time, a capacity for interpersonal relationships, love, and a desire to live. Some have embodied these qualities into a concept of "personhood."[2/3] Thus, the degree of life possessed when the final moment approaches may be only a scintilla as compared to a healthy and vigorous person. A newborn does not have the qualities of personhood yet but may possess the potential absent severe congenital abnormalities. Although it is difficult to quantitate the qualities that make up personhood and hence it has been criticized by some, it is nonetheless a useful attempt to separate suffering and vegetative life from the reasonably pain-free, thinking and feeling form.[4] Thus, the degree of personhood that one possesses at any given moment will depend on a qualitative and quantitative assessment of that individual at that time. This is in no way intended to imply that the reverence and respect for life should vary with its stage or its degree of personhood. The privilege of life (or gift of it from a theological point of view) should be respected in all of its stages and in my view in all of its forms.

1. Kubler-Ross, E.: *DEATH, The Final Stage of Growth.* First Edition. Inglewood Cliffs, New Jersey, Prentice-Hall, Inc., 1975.

2. Engelhardt, H. T.: *The Beginnings of Personhood: Philosophical Considerations.* Perkins Journal 27:20-27, 1973.

3. Outler, A. C.: *The Beginnings of Personhood: Theological Considerations.* Perkins Journal 27:28-34, 1973.

4. Hudson, R. P.: *Death, Dying and the Zealous Phase.* Annals of Internal Medicine 88:696-702, 1978.

Reprinted courtesy of the *Journal of the Kansas Bar Association,* vol. 49, Winter, 1980.

Rather, it is an attempt to discriminate between meaningful and meaningless or hopeless existence. It is at this point that the subject of euthanasia becomes germane.

Euthanasia is derived from the Greek words eu, meaning normal, and thanatos, meaning death. Colloquially it has come to mean "mercy-killing." The definition in a medical dictionary is "an easy or painless death" or "mercy-killing."[5] A legal dictionary's definition is "the art or practice of painlessly putting to death persons suffering from incurable and distressing disease" or "an easy or agreeable death."[6] Thus, both professions' dictionaries recognize a non-criminal meaning of the word but in reverse order of preference.

Both legal and medical writers now recognize several types of euthanasia. Active or direct euthanasia is where an affirmative act directly results in death while passive euthanasia occurs when a person is allowed to die due to the natural consequences

Both legal and medical writers now recognize several types of euthanasia.

of their disorder due to an omission or non-act. Voluntary euthanasia involves the consent or personal wish of the patient (or another acting on his behalf) to bring about the act or non-act resulting in death while involuntary euthanasia occurs in the absence of the consent or wish of the patient or his representative. Thus, several combinations are possible. An example of voluntary-active (direct) would be intentionally giving someone, at their request, a fatal dosage of medication. Voluntary-passive (indirect) could occur by way of a living will, if respected by the physician, or by way of a natural death act where it has been enacted. Involuntary-active (direct) is obvious in that it involves deliberately performing an act resulting in death without the personal consent of the individual. Involuntary-passive(indirect) occurs when a non-act results in death without the consent of the person. Although subject to some dispute, the removal of life support apparatus (*e.g.*, mechanical respirator) has generally been interpreted as a passive or indirect procedure in spite of the fact that turning the switch to "off" or pulling the plug is an act. The reasoning behind this view is that the person dies from the natural consequences of the disease process rather than the act in this particular circumstance.

MEDICAL ISSUES

The physician and other health care providers by the nature of their work, play a major role in euthanasia decisions. Most physicians will acknowledge participating in voluntary-passive euthanasia where either the patient or someone acting on his behalf requests that further definitive treatment of the specific disorder not be continued and only comfort measures or symptomatic treatment be performed. Please note that the patient is not left devoid of all treatment as is sometimes implied. To the contrary, all measures which offer comfort, relief, and alleviation of pain and suffering are continued as aggressively as needed to maintain the patient, to the extent possible, in a state of comfort. This symptomatic therapy has been referred to in the legal literature as ordinary measures, whereas the omitted therapy has often been referred to as extraordinary or heroic measures. There is difficulty here in terminology for several reasons. Firstly, what was considered as extraordinary a few years ago may now be ordinary from the medical point of view. For example, antibiotics, intravenous fluids, transfusion of blood, and blood products, are now rather ordinary types of medical treatments and yet it is withholding such a therapeutic modality that may well permit or allow an elderly, vegetative patient to have his final wish. Pneumonia was once referred to as "an old man's best friend" and antibiotics can frustrate that person's very desire to allow God and nature to have their way. Secondly, the terms ordinary and extraordinary do not discriminate as precisely as definitive treatment (which may or may not include extraordinary measures) and symptomatic treatment in terms of what is actually done. To a physician, ordinary therapy is that therapy which is customary, common, and relatively safe. Extraordinary therapy would be those that are generally high risk or experimental, or very aggressive under the circumstances (*e.g.*, resuscitating a 90-year old person) or very expensive, or available on only a limited scale (*e.g.*, small supply of a new drug). As can be seen, voluntary - passive euthanasia could involve the withholding of antibiotics in a variety of clinical settings. Most physicians would state that antibiotics represent ordinary therapy. The physician who accepts a patient has a duty, according to the law, to use ordinary means to preserve his patient's life but no corollary duty to employ extraordinary means.[7] Foreman defines ordinary treatment as all medicines, treatments, and operations which offer reasonable hope of benefit and which can be obtained and used without excessive pain or other inconvenience. Extraordinary treatment is those means which cannot be obtained and employed without considerable expense, pain, or other inconvenience and which provide no reasonable hope of lasting benefit. The central question is how reasonable hope and lasting benefit would be construed. If it is in a narrow sense, that is the patient's immediate illness, rather than a broad sense, that is the overall welfare of the patient, then the law would be very threatening to the physician and his ethical position of giving life to years rather than mere years to life.[8] Said in other words, it is not the mere number of days one lives but the quality of them that is most meaningful. The crucial judgment concerns benefit to the patient in its fullest sense. That infers that before a means is determined to be ordinary or extraordinary a judgment must be made regarding the patient's physical, mental, spiritual, psychological, and financial situation, and, most importantly, his personal wishes if known or ascertainable from another.[9]

The physician who accepts a patient has a duty, according to the law, to use ordinary means to preserve his patient's life but no corollary duty to employ extraordinary means.

5. Dorland's Illustrated Medical Dictionary. Twenty-Fifth Edition. Philadelphia, W. B. Saunders Co. 1974, p. 553.

6. Black's Law Dictionary. Revised Fourth Edition. St. Paul, Minn., West Publishing Co. 1968, p. 654.

7. Foreman, P.: *The Physician's Criminal Liability for the Practice of Euthanasia.* Baylor Law Review 27:54-61, 1975.

8. Barton, D. and Hollender, M. H.: *Death Takes a Holiday—Reconsidered.* The Pharos 36:20-22, 1973.

9. O'Rourke, K. D.: *Active and Passive Euthanasia: The Ethical Distinctions.* Hospital Progress 57 (11): 68-73, 1976.

Having suggested that definitive and symptomatic treatment is a more accurate classification than ordinary and extraordinary treatment, one must also point out that even the former terminology is not without some moral and clinical difficulties. This comes into focus if one notes that voluntary-passive euthanasia could involve withholding or withdrawing definitive therapy. That is, withdrawing definitive treatment measures could be morally different than merely not initiating it in the first place. To illustrate, definitive therapy (treatment aimed at controlling or correcting a specific disease state) could be directed at both the illness causing the terminal condition as well as other pre-existent disorders. An example could be an insulin requiring diabetic who acquires a malignancy and, when terminal, exercises his right of voluntary-passive euthanasia and requests only symptomatic care. There is no problem in discontinuing the chemotherapy aimed at his malignant disorder but what about withdrawing the insulin he has taken for many years? Clouser makes a persuasive argument that withholding therapy is morally different in kind than withdrawing therapy and furthermore withdrawing an aggressive or heroic measure (*e.g.*, mechanical respirator) is substantially different from withdrawing a routine, regularized, and expected item of care such as insulin for a diabetic or digitalis for a cardiac patient. This latter type of measure is expected and relied on by the patient and should be continued.[10] This reasoning could be used to help decide which definitive therapies should be continued when most are in fact being stopped in a given patient.

The role of the physician in involuntary-passive euthanasia would probably not be acknowledged so readily in view of the physician's sensitivity to legal liability. However, most physicians are faced at times with hopelessly ill patients who can no longer communicate their consent or personal wishes and for whom no relative or friend is available to act on his behalf. From a legal point of view such a situation would require appointing a guardian to exercise his or her "vote." This area will be discussed in more detail under the section on case law, infra, but in passing it should be mentioned that acting in a paternalistic fashion many patients have probably been treated as the physician thought best in his judgment at the time of the illness.

The role of the physician in active euthanasia (voluntary or involuntary) not only violates the law but is outside the scope and purpose of the medical profession and is unethical in my opinion. The legal aspects of deliberately terminating life as a direct result of an affirmative act will be dealt with later. The physician's role in society is to console, alleviate pain and suffering, and cure when possible. To alleviate pain and suffering by not protracting the natural dying process is morally different than directly terminating life notwithstanding the views of others. Fletcher has stated that there is no moral difference between active and passive euthanasia. As a consequentialist, the result is the same whichever route is taken.[11] Even more iconoclastic is the view of Rachels which holds that active euthanasia is more humane than passive since the period of pain and suffering will actually be shortened.[12] These latter opinions fail to take into consideration the fact that the means to the end has a morality of its own and must be evaluated as to its nature and purpose.[9] Active euthanasia also presumes one has absolute dominion over his own life or that of another which is contrary to Judeo-Christian belief and the power of the State.

To alleviate pain and suffering by not protracting the natural dying process is morally different than directly terminating life . . .

As mentioned previously, active euthanasia would seem to be outside of the scope and responsibility of the medical profession even if permitted by ethics, religion, and the law. The basic purpose of the physician is to preserve life. If he also served as the terminator of life, the trust a patient places in a physician could be seriously eroded. Once a patient (or the representative on his behalf) has elected to seek active euthanasia the physician is actually no longer needed except to certify that the medical condition is indeed hopeless. If ever permitted, this act could be performed by someone other than a physician for there is no technical difficulty in giving someone a lethal intravenous dose of a medicine. As Hudson points out, it is no trick to hit a vein with a dose of morphine as thousands of addicts prove daily.[4] By analogizing to the legal profession, the trier of fact whether it be judge or jury may yield a guilty verdict but neither is asked to execute or carry out the sentence.

In addition to the issues previously discussed, the physician-patient relationship can be complicated by factors perhaps not obvious to nonphysicians. Firstly, a patient's apparent expression regarding his decisions concerning the dilemmas of dying may be spurious or inappropriate in some circumstances. Jackson and Younger have illustrated several clinical situations where the patient's "wish" may be distorted or erroneous due to depression, ambivalent feelings, an underlying unrecognized problem or an unjustified fear of treatment to mention only some. Such clinical situations could undercut what otherwise appears to be a sound decision on the part of the physician and patient and emphasizes the need for making euthanasia decisions only after the patient has been thoroughly and carefully evaluated.[13] Secondly, where the family is acting on behalf of an incompetent patient, the decision making process can be frustrated by the family being divided in its views, uncertain or lacking confidence in its position, or by abdicating this responsibility explicitly or implicitly. In such instances a physician may find himself "forced" into a paternalistic posture in the decision making process.[14]

Finally, how does one manage a subsequent illness or injury which is truly independent of an underlying terminal illness? An example could be a patient with advanced carcinomatosis who has an acute myocardial infarction. Logic and consistency would seem to dictate that since the illness responsible for the

10. Clouser, K. D.: *Allowing or Causing: Another Look.* Annals of Internal Medicine 87:622-624, 1977.

11. Fletcher, J.: *The "Right" to Live and the "Right" to Die.* The Humanist 34:12-15, 1974.

12. Rachels, J.: *Active and Passive Euthanasia.* New England Journal of Medicine 292:78-80, 1975.

13. Jackson, D. L. and Younger, S.: *Patient Autonomy and "Death With Diginity."* New England Journal of Medicine 301:404-408, 1979.

14. Relman, A. S.: *A Response to Allen Buchanan's Views of Decision Making for Terminally Ill Incompetents.* American Journal of Law & Medicine 5 (2):119-123, 1979.

underlying terminal state continues, then the approach to the new illness should be in concert philosophically with the treatment for the pre-existent illness. Hence, if only symptomatic measures are being rendered for the terminal disorder, then only symptomatic measures should be directed at the intervening disorder. Thus, in the example given above and if the patient had opted for voluntary-passive euthanasia, then only symptomatic treatment would be indicated for both the carcinomatosis and the acute myocardial infarction. Accordingly, such a patient should not be resuscitated for a cardiac arrhythmia or even admitted to any acute care unit since such treatment would be inconsistent and inappropriate for the patient's total condition.

To a certain extent, the ethical and legal dilemmas facing today's physician is a problem created by medical progress. The answers are not obvious but the questions must be examined critically with the hope of shedding wisdom and light where there is now confusion.

LEGAL ISSUES

A. Constitutional Law and Common Law

The United States Supreme Court has in recent years recognized a constitutional right of privacy as one of our fundamental rights. Within the protective ambit of this right comes such personal decisions as marriage, contraception, procreation, abortion, and the raising and educating of children.[15/16/17/18] Although the United States Constitution does not explicitly mention a right to privacy, it has been held to derive its roots from the First Amendment, Fourth Amendment, Fifth Amendment, Ninth Amendment, Fourteenth Amendment and the penumbras of the Bill of Rights.[17] The decisions assert that only those personal rights that can be deemed fundamental or implicit in the concept of ordered liberty are included in this guarantee of personal privacy. The Court in *Roe* based the right of privacy on the Fourteenth Amendment through its concept of personal liberty and restriction on state action. The Court also pointed out such rights are not absolute and must be balanced against the state's interests in safeguarding health, maintaining medical standards, and protecting life including that which is only potential. Today many commentators are asserting that the choice of death or the right to die also falls within this area of constitutional protection.[19/20] That is, the right of privacy includes the right to die since this too, is a fundamental decision affecting a person. State interests that could be asserted in balancing this qualified right include the following: 1) the duty to protect the lives of persons, 2) the maintenance of medical standards to prevent hasty or erroneous decisions, 3) the possibility that it is a violation of medical ethics, 4) the sanctity of life could be undermined, and that recognition of such a right could serve as an entering wedge for compulsory elimination of the aged, the unproductive, and the genetically defective, and 5) that society depends on the existence and productivity of its members and that death of some will leave dependents destitute and unable to care for themselves.[19] Those in favor of this right argue that the case for it is even stronger than abortion since no third being is involved. Furthermore, most of the state's interests diminish with time and are greatly attenuated in the cases of persons who are debilitated because of advanced age, whose medical condition is hopeless, and for whom continued medical treatment poses an unacceptable burden. Even prior to the United States Supreme Court decisions, Justice Cardozo, while a member of the New York Court of Appeals, stated that "every human being of adult years and sound mind has a right to determine what shall be done with his body," that is, a right of self-determination.[21] That would appear to include the right to be left alone mentioned in a United States Supreme Court case a decade ago.[22] Hence, it would appear that sound common law and constitutional arguments can be marshalled for asserting the choice of death as an aspect of the rights of self-determination and privacy respectively. Of course, one is not dealing with choice of death in its inevitable sense but rather choice of the time and manner of death as a natural event without intervention by medical treatment.

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B. The Physician's Criminal Liability

As pointed out by Foreman, whatever the definitional difficulties are regarding euthanasia (type, etc.) it is clear that *theoretically* the physician is criminally liable under almost any factual situation one can imagine. However, it is of interest that there have been few prosecutions and essentially no convictions in the history of American jurisprudence regarding this problem.[7] Involuntary-active euthanasia (*i.e.*, without consent by a positive act) is clearly murder, notwithstanding any kind or humane motive. This interpretation appears correct in terms of Kansas law where murder in the first degree is defined as "The killing of a human being committed maliciously,* willfully, deliberately, and with premeditation or committed in the perpetration or attempt to perpetrate any felony."[23]

Involuntary-passive euthanasia is perhaps less clear since the common law has imposed criminal liabilities for such deaths only where the person guilty of such an omission had a clear duty to act. This duty must be a legal one and not merely a moral one, and the omission of the duty must be the immediate and direct cause of death. A physician, once he or she accepts a patient, has a continuing obligation to use ordinary measures to preserve life, as a part of his contract with the patient. Hence, at least theoretically, if a physician voluntarily omits doing an act construed as ordinary treatment he could be criminally liable. As noted by Foreman, this liability appears to be only theoretical at present, since to his knowledge and that of several commentators there has never been a case dealing with this particular factual circumstance.

15. *Loving v. Virginia*, 388 U. S. 1, 87 S. Ct. 1817, 18 L. Ed. 2d 1010, 1967.
16. *Eisenstadt v. Baird*, 405 U. S. 438, 92 S. Ct. 1029, 31 L. Ed. 2d 349, 1972.
17. *Roe v. Wade*, 410 U. S. 113, 93 S. Ct. 705, 35 L. Ed. 2d 147, 1973.
18. *Wisconsin v. Yoder*, 406 U. S. 205, 92 S. Ct. 1526, 32 L. Ed. 2d 15, 1972.
19. Delgado, R.: *Euthanasia Reconsidered — The Choice of Death as an Aspect of the Right of Privacy.* Arizona Law Review 17:474-494, 1975.
20. Evans, F. J.: *The Right to Die—A Basic Constitutional Right.* The Journal of Legal Medicine 5 (8):17-20, 1977.
21. *Schloendorff v. Society of New York Hospitals*, 211 N. Y. 125, 105 N. E. 2d 92, 1914.
22. *Stanley v. Georgia*, 394 U. S. 557, 89 S. Ct. 1243, 22 L. Ed. 2d 542, 1969.

* Malice, legally, can mean a man-endangering state of mind and not necessarily an evil motive.
23. Kansas Statutes Annotated (K.S.A.) 21-3401.

Voluntary-active euthanasia would also appear to satisfy the criteria for murder since the common law has never recognized consent of the victim as a defense to criminal homicide. A lesser included crime under these circumstances would be that of assisted suicide. Here one merely aids or abets the suicide rather than deliberately taking the life, a subtle distinction (*e.g.*, preparing the poison as contrasted to giving it). Although suicide per se is no longer a crime in the majority of American jurisdictions, assisted suicide often is. In Kansas assisting suicide is "intentionally advising, encouraging, or assisting another in the taking of his own life." It is a Class E felony.[24]

Voluntary-passive euthanasia again raises the issue of whether or not the physician had a legal duty to act. If the patient disengaged or withdrew from treatment thereby cancelling the physician's legal duty to treat with ordinary measures, then no criminal liability would lie. Again, *theoretically*, if the physician-patient relationship still existed and the physician withheld ordinary measures then potential criminal liability could attach if the deliberate non-act or omission could be shown to be the direct and immediate cause of death (*e.g.*, withholding corticosteroids in a patient with adrenal insufficiency).

C. The Physician's Civil Liability

The common law did not provide a civil cause of action for death. In England one was created by statute under Lord Campbell's Act and in the United States American legislatures have followed this example by creating wrongful death statutes. Kansas has enacted such legislation in Kansas Statutes Annotated (K.S.A.) 60-1901 through 1905. The cause of action states as follows:

> "if the death of a person is caused by the wrongful act or omission of another, an action may be maintained for damages resulting therefrom if the former might have maintained the action had he or she lived, in accordance with this article, against the wrongdoer, or his or her personal representative if he or she is deceased."

At present the aggregate sum of the damages other than for pecuniary loss cannot exceed $25,000.00.[25] The elements of damage which may be recoverable include mental anguish, suffering or bereavement; loss of society, companionship, comfort or protection; loss of marital care, attention, advice, or counsel; loss of filial care or attention; loss of parental care, training, guidance or education, and the reasonable funeral expenses of the deceased. If no probate of administration for the estate of the deceased has been commenced, expenses for the care of the deceased which resulted from the wrongful act may also be recovered by any one of the heirs who paid or became liable for same. Neither the expenses for such care nor funeral expenses are included within the $25,000.00 limitation.[26] The action may be commenced by any one of the heirs at law of the deceased who sustained a loss by reason of the death.[27] Also to be considered would be the survival statutes which allow certain actions to survive notwithstanding the death of the person entitled to bring the action on the person liable for the same. It includes causes of action the deceased could have brought at common law for mesne profits, for injury to the person, or to the real or personal estate, or for any deceit or fraud, or for the death by wrongful act or omission.[28] Furthermore, no action pending shall abate by the death of either or both parties thereto, except an action for libel, slander, malicious prosecution, or for nuisance.[29]

At the outset it should be stated that there are no reported cases of civil liability for euthanasia.[30] Consequently, one can only discuss it from the point of view of theory, logic, and policy. Two doctrines, standard of care and informed consent, seem relevant to this area of liability. It is well established that a medical treatment or operation performed without consent, notwithstanding a good result, can be an intentional tort, i.e., a technical battery.[31/32] Thus, even if the physician does not deviate or depart from the standard of care, liability can attach for an intentional act absent consent. Conversely, in most situations, consent, absent deviation from the standard of care will absolve the physician from civil liability. A situation that has been litigated several times involves the competent patient who refuses a life-saving procedure, *e.g.*, refusal of blood transfusion with an underlying curable disorder. The courts are divided in compelling the treatment under such circumstances. On some occasions the presence of harm to others (*e.g.*, death of parent with young children) has been a factor in the outcome. Thus, it is a question of balancing the right of privacy previously discussed against the state interests involved. Assuming that a patient does have a right to choose his mode and manner of death and rejects life saving or prolonging treatment, does the physician have any civil liability? The answer appears uncertain at present but in legal theory the patient's right to refuse treatment coupled with the physician's duty to refrain from treatment absent consent would support a result of no liability for the physician. In reference to the previous statutory causes of action the underlying wrongful act must be of such a character that the patient would have been entitled to recover if alive. If the patient has the right to refuse treatment and the physician commits no wrongful act, then the statutory beneficiaries should not be able to recover since the patient himself could not. Thus, if a competent terminal patient rejected life prolonging treatment, it would seem that the physician should not be liable.

. . . if a competent terminal patient rejected life prolonging treatment, it would seem that the physician should not be liable.

If a mentally competent patient requests or demands that a death inducing agent be given, a different situation arises since this is voluntary-active euthanasia. Traditionally, consent has vitiated the wrongfulness of an intentional tort. However, this factual situation is criminal and it is clear that one cannot consent to criminal conduct. Apparently jurisdictions vary on whether assent to a criminal act bars civil liability.[30] In Kansas this act would clearly violate the assisting suicide statute previously mentioned as well as possibly the murder statutes.

24. K.S.A. 21-3406.
25. K.S.A. 60-1903.
26. K.S.A. 60-1904.
27. K.S.A. 60-1902.
28. K.S.A. 60-1801.
29. K.S.A. 60-1802.
30. Sharp, Jr., T. H. and Crofts, Jr., T. H.: *Death With Dignity—The Physician's Civil Liability.* Baylor Law Review 27:86-108, 1975.
31. *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12, 1905.
32. Thurman, V.: *Euthanasia: The Physician's Liability.* The John Marshall Journal of Practice and Procedure 10:148-172, 1976.