Opinion
Guest Voices

Julia Quinlan stands next to a photo of daughter Karen Ann at the Center of Hope Karen Ann

Julia Quinlan stands next to a photo of daughter Karen Ann at the Center of Hope Karen Ann Quinlan Hospice Feb. 24, 2005, in Newton, N.J. In October 1975, Julia and her husband, Joe, sought a court order to have Karen's respirator turned off so she could die naturally. On Nov. 10 of that year, the judge denied the request. The Quinlans appealed and won a reversal on March 31, 1976, and their daughter was weaned off the respirator. She died June 11, 1985. (CNS/The Beacon/Joe Gigli)

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March 31, 2026, marks 50 years since a landmark decision that shapes American patients' rights every day: the New Jersey Supreme Court ruling in the case of Karen Ann Quinlan, who had suffered an irreversible coma.

Quinlan's case established for the first time that decisions near the end of life should be made by patients and families, not by doctors and hospitals alone. As a bioethicist, I have taught and written extensively about the profound impact the

Quinlan case has had on law, bioethics and the pursuit of death with dignity.

The Quinlan story

In April 1975, at the age of 21, Karen Ann Quinlan suffered a cardiac arrest and loss of oxygen to the brain while at a friend's party. After she had gone to bed, friends discovered that she had stopped breathing, and she was rushed to the hospital.

After a while, doctors determined that Quinlan was in a persistent vegetative state: a condition in which all cognitive functions of the brain have been lost and the patient has no awareness of themselves or their environment. People in a persistent vegetative state retain some brain stem functions that regulate involuntary bodily activities, such as heart rate, blood pressure and digestion, but cannot live without continuous care and treatment. Some patients breathe independently with a feeding tube and other care. Quinlan needed both a respirator and a feeding tube.

When a persistent vegetative state is properly diagnosed, recovering cognitive ability is extremely rare.

End-of-life decision making

For Catholic resources, with state-specific information, click here.

After months of agonizing over their daughter's plight, the Quinlans decided she would not want her biological life prolonged indefinitely in this condition and that it was not in her best interests. The family knew Karen as a very active, athletic and energetic young woman, who, when terminally ill people she knew had received aggressive treatments, had said she would not want similar measures.

Joseph and Julia Quinlan were devout Catholics who met often with their parish priest. He explained that Catholic teachings permitted removal of extraordinary treatments, like the respirator, that impose pain, suffering and excessive burdens without possibility of recovery. Many Catholic theologians believe that ordinary care and treatment such as feeding tubes, on the other hand, should be continued.

The parents requested the respirator be removed and that their daughter be allowed to die. But the doctor and hospital refused, prompting her family to go to court.

At trial

The Quinlans were represented by Paul Armstrong. He became their champion both in a court of law and in the court of public opinion amid the onslaught of press coverage.

At the heart of the case was the argument that patients have a constitutional right of privacy to refuse treatment, including life-sustaining treatment.

Joseph Quinlan, left, and Julia Quinlan go over mail received by Fr. Thomas Trapasso, pastor of our Lady of the Lake Church in Mount Arlington, Jan. 25, 1976. The Quinlans requested doctors remove their daughter's respirator and that she be allowed to die. But the doctor and hospital refused, prompting her family to go to court. (AP)

The Quinlans argued that Joseph should be appointed Karen's guardian to exercise this right on her behalf, with authority to decide to remove the respirator. They contended that this should be understood as allowing a natural dying process to take its course, not as an act of suicide or homicide. No case had ever presented these principles to a court of law.

The doctors and hospital, along with local and state prosecutors, argued that there was no such right to die and that preservation of life was paramount. Two of the medical professionals' claims stand out. First, that to continue the respirator was for medical experts to decide, not the patient or family. Second, that accepted norms of the profession required aggressive interventions to sustain life. Extending the patient's life mattered more than its quality.

On Nov. 10, 1975, the trial court ruled against the family and held that the doctors and hospital had no obligation to comply with the family's request. They could continue the respirator and decide whether and when it should be removed.

The Quinlans appealed to the state Supreme Court.

Landmark decision

On March 31, 1976, the New Jersey Supreme Court issued a unanimous opinion in favor of the Quinlans. The justices held that patients have a constitutional right of privacy to refuse unwanted life-sustaining treatments and that this right should not be lost when illness, disease or disability take away our ability to choose for ourselves. Family members may decide on behalf of incompetent loved ones, basing decisions on what the patient would want and acting in their best interests.

Stating the broader principles of the case, Chief Justice Richard Hughes wrote that the patient's wishes are "predominant" even when doctors disagree, and these decisions must "be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large." With these words, the decision rejected centuries of physician paternalism — of "doctor knows best." It ushered in the era of patient autonomy that puts patients and families first at the bedside.

The case would transform how decisions near the end of life are made and by whom. It also planted the seeds for hospital ethics committees and consultants who today serve to ensure sound decision-making and to help resolve disagreements privately without going to court.

The decision did not bring an end to the family's painful journey, nor to public interest in the case. After the decision, the physicians removed and reattached the respirator, taking it away for progressively longer periods of time. Eventually, Quinlan was able to breathe on her own, while still in a vegetative state.

True to their Catholic faith, the Quinlans believed the feeding tube sustaining Karen's life to be ordinary care that should be continued and that it was not causing her pain. They never asked that it be removed. Their daughter died from pneumonia nine years later on June 11, 1985.

End-of-life consensus

In the 15 years or so after the New Jersey ruling, courts across the nation saw their own end-of-life controversies and followed the core principles of the Quinlan decision to resolve them.

Meanwhile, state legislatures had another answer for the essential question: What would the patient want?

A decade after the Quinlan case, New Jersey created a Bioethics Commission to study advancing health care technology in light of the decision's principles. The commission's proposed legislation establishing advance directives was enacted on July 11, 1991. I was privileged to lead this project, as staff to the commission.

Today, all 50 states have advance directive laws that allow competent adults to plan ahead and put their wishes for end-of-life care in writing.

The rapid emergence of a national judicial and legislative consensus added several principles to the Quinlan framework: Treatment refusal rests on the inherent right of self-determination and does not depend on how the Constitution is interpreted. These same rights belong to those suffering from advanced cancer, heart disease or other terminal conditions. And patients may refuse any and all medical interventions, including feeding tubes.

These are all pillars of today's legal, ethical, medical and social consensus around end-of-life care.

Put it in writing

Today, many Americans take the fundamental right to refuse unwanted treatments for granted and put off planning for life's end. These are not easy conversations to have. According to a 2020 University of Michigan study, only 59% of adults ages 50-80 have discussed their treatment preferences with family members or another trusted person, and less than 50% have completed an advance care planning document.

I believe this anniversary is an occasion to appreciate these important rights and to consider putting wishes for end-of-life care in writing.

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