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Equal but Incompetant: Procedural Implementation of a Terminally Ill Person's Right to Die

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EQUAL BUT INCOMPETENT: PROCEDURAL IMPLEMENTATION OF A TERMINALLY ILL PERSON'S RIGHT TO DIE

I. INTRODUCTION

In nonemergency situations medical and legal ethics stipulate that physicians may begin treatment only with a patient's consent.[1] But what of the case of the terminally ill patient who, due to age, illness, or mental retardation is incapable of consenting to potentially painful, non-life saving treatment? The question is not far-fetched; doctors caring for the critically ill frequently encounter this uncomfortable dilemma.[2]

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1. Relman, *The* Saikewicz *Decision: Judges as Physicians*, 298 NEW ENG. J. MED. 508 (1978).

The common law of every state prohibits doctors from administering medical treatment without the patient's informed consent. Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 248 (1977). Numerous states have specific medical consent statutes. *See, e.g.*, FLA. STAT. § 768.46 (1983).

"Good Samaritan" Acts enacted in many states relieve medical personnel of liability when they act in good faith in an emergency situation. *See, e.g.*, FLA. STAT. § 768.13 (1983).

2. Note, *The "Living Will": The Right to Death With Dignity?*, 26 CASE W. RES. 485, 486 (1976). If the doctor ignores specific desires expressed by a patient and administers unwanted treatment without consent, he may be civilly and criminally liable for assault and battery. *Id. See, e.g.*, Collester, *Death, Dying and the Law: A Prosecutorial View of the* Quinlan *Case*, 30 RUTGERS L. REV. 304, 305 (1977). For a discussion of involuntary passive euthanasia constitut-

Recent advances in medical science have fostered this predicament by dramatically increasing a person's average life expectancy.[3] In addition, technology has created machines capable of keeping a patient "alive" long after death.[4] Medical decisionmaking is further complicated by the patient's desire to exert personal control over medical destiny and an upsurge of interest in "death with dignity."[5]

Many people, fearing a long and protracted death, have asserted their "right to die" by executing a document known as a "living will." The "living will" instructs physicians to allow death if no reasonable chance of recovery exists.[6] This marked preference for natural death[7]

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ing homicide, see Sanders, *Euthanasia: None Dare Call it Murder*, 60 J. CRIM. L. 351 (1969), but see Elkington, *The Dying Patient, the Doctor and the Law*, 13 VILL. L. REV. 740 (1968) (claiming that a person is no longer a human being when he has lost his ability to maintain a conscious, reasoning state).

3. *See* STATISTICAL ABSTRACT OF THE UNITED STATES 1984 at 73 (104th ed.).

4. Technical advances in medicine now permit maintenance and support of cardiac and respiratory function in man long after massive or even total destruction of the brain occurs. Zimring, *Medical Judgment v. Court Imposed Rules; In Treatment of Terminally Ill Patients*, 81 N.Y. ST. J. MED. 951 (1981). An unconscious patient may therefore be rushed to the emergency room after cardiac arrest and be placed on machines which will save his "life" but leave him with a brain severely and irreversibly damaged. Report of the Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J. A.M.A. 337, 339 (1968). *See generally* Note, *Involuntary Passive Euthanasia of Brain-Stem-Damaged Patients: The Need for Legislation—An Analysis and a Proposal*, 14 SAN DIEGO L. REV. 1277 (1977).

Florida has statutorily recognized brain death and relieved all medical personnel of liability when a "brain dead" determination is made in compliance with this provision. FLA. STAT. § 382.085 (1983).

5. Commentators have noted a growing interest in death among the American public. *See* E. KUBLER-ROSS, ON DEATH AND DYING 11-12 (1969); *see, e.g., Euthanasia and the Care of the Dying*, DILEMMAS OF EUTHANASIA 1, 10, 12-14 (J. Behnke & S. Bok, eds. 1975); R. VEATCH, DEATH, DYING AND THE BIOLOGICAL REVOLUTION 17 (1976). This increased interest has resulted in a united effort by physicians to formally recognize the patient's right to participate in treatment decisions. *See* G. ANNAS, THE RIGHTS OF HOSPITAL PATIENTS: THE BASIC ACLU GUIDE TO A HOSPITAL PATIENT'S RIGHTS 4 (1975); Mills, *On Death and Dying Laws*, J. LEGAL MED. Aug. 1977, at 3.

6. Note, *supra* note 2, at 485. A "living will" is a document, similar to a will, executed by a person during his lifetime which sets forth his desires concerning medical treatment in contemplation of illness or death. Note, *In re Living Will*, 5 NOVA L.J. 455, 445 n.1 (1981). In the past twelve years, more than six million copies of living wills have been sent to the public pursuant to their request. 6 CONCERN FOR DYING NEWSLETTER 2 (Spring 1980). In addition, periodicals assert the need for natural death legislation. *See, e.g.*, Akers, *The Living Will: Already a Practical Alternative*, 55 TEX. L. REV. 665 (1977); Kutner, *The Living Will: Coping with the Historical Event of Death*, 27 BAYLOR L. REV. 39 (1975); Note, *Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute*, 64 IOWA L. REV. 573 (1979); Note, *The Right to Die: A Proposal for Natural Death Legislation*, 49 U. CIN. L. REV. 228 (1980).

The Euthanasia Education Council distributes a Model Living Will, which states:

> TO MY FAMILY, MY PHYSICIAN, MY LAWYER, MY CLERGYMAN TO ANY MEDICAL FACILITY IN WHOSE CARE I HAPPEN TO BE TO ANY INDIVIDUAL WHO MAY BECOME RESPONSIBLE FOR MY HEALTH, WELFARE OR AFFAIRS

over mechanically extended life has created agonizing legal, medical and ethical problems for the health care profession and the judiciary. The problem is acute when an incompetent[8] patient has previously executed a natural death directive. It is here that current law is most confused.

Courts addressing the issue have acknowledged that a competent individual's right of privacy includes the right to be free of bodily invasion.[9] Yet, these courts have not recognized an incompetent's right against such bodily intrusion. Florida, for example, specifically differentiates between these two patient classes. Though a competent patient may effect his right to die under Florida law without judicial interference,[10] an incompetent patient must obtain court approval through a guardian before termination of extraordinary medical care is allowed.[11] Such judicial intervention is required despite the incom-

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Death is as much a reality as birth, growth, maturity and old age—it is the one certainty of life. If the time comes when I, ——— can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures." I do not fear death itself as much as the indignities of deterioration, dependence and hopeless pain. I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

Signed _____
Date _____
Witness _____
Witness _____
Copies of this request have been given to: _____

See Dempsey, *The Living Will—and the Will to Life*, N.Y. Times, June 23, 1974, § 6 (Magazine), at 12, 26.

7. Natural death, or antidysthanasia is defined as "failure to take positive action to prolong the life of an incurable patient. . . ." S. SHINDELL, THE LAW IN MEDICAL PRACTICE 118 (1966). This is to be distinguished from euthanasia, defined as the taking of positive action to end the life of an incurable patient. *Id.*

8. For purposes of this note, an incompetent patient refers to a patient in a vegetative or comatose state without ability to think or reason.

9. Satz v. Perlmutter, 362 So. 2d 160 (4th D.C.A. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980). *See also* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Schiller, 148 N.J. Super. 168, 372 A.2d 360 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

10. *Satz*, 379 So. 2d 359 (Fla. 1980). *See infra* text accompanying notes 78-98.

11. J.F.K. Memorial Hosp. v. Bludworth, 432 So. 2d 611 (Fla. 4th D.C.A. 1983). *See infra* text and accompanying notes 99-121.

petent's prior execution of a living will.[12] This vague and differential treatment of a fundamental constitutional right is, at the very least, suspect.[13] Furthermore, these decisions enunciate arbitrary, case specific procedures which fail to answer numerous questions concerning the legal validity of a living will.

Until a decisive course is charted, members of the medical profession remain in legal limbo. Physicians may be forced to overtreat some patients and undertreat others due to constant fear of costly malpractice suits.[14] Current legal and medical confusion surrounding the physician's duty and the incompetent's rights has precipitated a precarious situation for the patient, the physician, and the court. In response, Florida courts must protect an incompetent's right to privacy by recognizing the legal validity of a living will and delineating clearcut guidelines for its implementation.

This note examines recent judicial recognition of the terminally ill patient's right to die.[15] While the competent patient may exercise the right unencumbered by the judiciary, the incompetent patient must receive judicial approval to remove life-sustaining devices. This note submits that mandatory judicial intervention abridges the incompetent's right to die. Where an incompetent has previously executed a valid living will, courts should acknowledge this declaration without intervention. To achieve this result, guidelines will be proposed to facilitate the implementation of natural death legislation in Florida.

II. Privacy Rights to Bodily Autonomy

The right to be let alone is among the most zealously guarded personal rights.[16] This fundamental privacy right, contained in the

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12 *Id.* Through advanced declaration, a Living Will eliminates the need to determine the declarant's competency at the time of implementation. Such an advance decision allows the maker time to reflect on his choice both before and after execution. This may in fact be preferable to a contemporaneous assertion of a patient's desire when critical illness has set in, since at that time death related factors may distort competency. Note, *supra* note 2, at 511. *See also* Gurney, *Is There a Right to Die—A Study of the Law of Euthanasia*, 3 Cum.-Sam. L. Rev. 235, 260 (1971).

13. *See, e.g.*, Doe v. Bolton, 410 U.S. 279 (1972) (holding a Georgia abortion statute unconstitutional because it mandated committee overview of doctor/patient abortion decisions).

14. Relman, *supra* note 1, at 508. *See also* Hushen, *Dilemmas in Practice: Questioning TPN as the Answer*, 1982 Am. J. Nursing 852, 854. *See also* MacDonnell, *"No Resuscitation" Orders*, 1981 Can. Med. A.J. at 809.

15. This right is encompassed in the constitutional right of privacy. Though the Constitution does not expressly mention the privacy right, the Supreme Court has recognized this guarantee as implicit in the Bill of Rights. *See* Griswold v. Connecticut, 381 U.S. 479, 484-85 (1965). The Court has also attributed this protection to the fourteenth amendment. *See* Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

16. Olmstead v. United States, 277 U.S. 438, 478 (1927) (Brandeis, J., dissenting). In his now famous dissent Justice Brandeis stated: "The makers of our Constitution. . .conferred, as

penumbra of the Bill of Rights' guarantees,[17] extends to all people, competents and incompetents alike.[18] Though the Constitution does not specifically express a right of privacy, early United States Supreme Court cases recognized an individual's right to possession and control of his own person, free from restraint or interference, as one of the most sacred common law rights.[19]

The right to privacy was initially acknowledged in *Griswold v. Connecticut*[20] where the Supreme Court invalidated a state statute prohibiting the use of contraceptives by married couples. Writing for the Court, Justice Douglas asserted that the amendments to the Bill of Rights created "zones of privacy."[21] In his concurring opinion, Justice Goldberg found the right of privacy in the ninth amendment which required states to demonstrate a compelling interest to restrict this right.[22] Justices White and Harlan considered the statute unconstitutional under the fourteenth amendment though they did not refer to "privacy" in their concurrence.[23] Thus, in recognizing this right to privacy, the majority failed to specifically define its parameters, leaving such development of a case-by-case methodology.[24]

Less than a decade later, the Court established precedence for broadening an individual's personal rights. In *Roe v. Wade*, the Court extended the right of privacy to encompass a female's decision to terminate pregnancy in the absence of compelling state interest.[25] The

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against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men." *Id.*

17. Griswold v. Connecticut, 381 U.S. 479 (1965) (holding the right of privacy to emanate from the guarantees of the first, fourth, fifth, ninth, and fourteenth amendments).

18. Superintendent of Belchertown State School v. Saikewica, 373 Mass. 728, 745, 370 N.E.2d 417, 427 (1977).

19. The Supreme Court recognized the importance of privacy values in Union Pacific R.R. v. Botsford, 141 U.S. 250 (1891). The Court stated:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law . . . "[t]he right of one's person may be said to be a right of complete immunity; to be let alone."

Id.

20. 381 U.S. 479 (1965).

21. *Id.* at 484.

22. *Id.* at 497.

23. *Id.* at 499, 502.

24. *Id.* at 479. *See* Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (recognizing the right of the individual to be free unwarranted governmental intrusion into matters fundamentally affecting a person); Stanley v. Georgia, 394 U.S. 557, 565 (1969) (holding that an individual has a right to privacy within his home which encompasses the right to read allegedly pornographic material).

25. 410 U.S. 113, 163 (1973). The Court also promulgated specific guidelines for the states to follow in allowing abortion. *Id.* In the first trimester, the Court found that a woman's deci-

Roe Court recognized the mental and physical burdens of child care and acknowledged a woman's distressful life which could result from having an unwanted child.[26] Every state that has considered the right of a terminally ill patient to be free from bodily invasion has consulted and relied upon the *Roe* decision.[27]

Although the Supreme Court has not specifically extended a privacy right to terminally ill patients refusing medical treatment, the extent of state interest in the life of a dying comatose patient can be examined by analogy to *Roe*. Under *Roe*, the state's interest does not become compelling until a fetus reaches viability[28] and is capable of meaningful autonomy outside the mother's womb.[29] While *Roe* focuses on the preservation of "potential" life, the preservation of waning life is similar.[30] In the face of imminent, inevitable death, the state theoretically loses its interest in preserving the potential for a return to functional life. Instead, the state adopts the same interest in a dying patient that it has for an unviable fetus.[31] In fact, the state's interest may be less in the case of a dying incompetent since, arguably, that person's meaningful life has permanently ceased.[32] Thus, courts considering the terminally ill patient's right to refuse medical treatment have assumed that constitutional privacy values extend beyond the procreative rights identified by the Supreme Court.[33]

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sion to terminate her pregnancy must be absolute and free of state intervention. In the second trimester, the state may regulate the place and manner of abortion procedures since it has a compelling interest in the mother's well-being due to a higher incidence of mortality after the first trimester. In the third trimester, the state's interest in the fetus' "potential" life becomes compelling and it may therefore prohibit abortion irrespective of the individual's desires, unless that individual's own life is in danger. *Id.*

26. *Id.* at 153. The Court also recognized the right of a woman to avoid the stigma of unwed motherhood. *Id.*

27. *See* cases cited *infra* note 122.

28. A fetus is viable, according to the Court, when it is potentially able to live outside the mother's womb, albeit with artificial aid, usually at about seven months. *Id.* at 160.

29. 410 U.S. at 161.

30. Comment, *Florida's Right to Die—A Question of Litigation or Legislation?*, 8 FLA. ST. U.L. REV. 111, 119 (1980).

31. *Id.* As specified in *Roe*, the state possesses no interest in the life of an unviable fetus. 410 U.S. at 163.

32. *See* Wolman, *Discontinuing Treatment for the Terminally Ill: Ethical Considerations*, 1981 CONN. MED. J. 731, 731-32.

33. *In re* Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976), *cert. denied*, 429 U.S. 922 (1976). *See, e.g.*, Stanley v. Georgia, 394 U.S. 557 (1969) (verifying that security from physical intrusion bears an important relation to fundamental personal privacy); *see also* Scott v. Plante, 532 F.2d 939 (3d Cir. 1976) (noting that involuntary administration of drugs to hospitalized psychiatric patient could constitute deprivation of privacy); Runnels v. Rosendale, 499 F.2d 733, 735 (9th Cir. 1975) (holding that performance of nonconsensual surgical treatment upon a prison inmate violated constitutionally protected rights to be secure in one's own body); *see generally* Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30

A. *The* Quinlan *Landmark—An Incompetent's Right to Die*

With the decision *In re Quinlan*,[34] New Jersey was the first state to extend *Roe* to include a privacy right to natural death. After twenty-two year old Karen Quinlan became comatose, physicians determined she would never again lead a cognitive life.[35] Karen's father petitioned for appointment as guardian ad litem to obtain authority to cease the extraordinary medical procedures keeping Karen alive.[36]

The *Quinlan* court held that, under certain circumstances, the fundamental right of personal privacy as described in *Griswold* and *Roe* encompassed a patient's decision to decline medical treatment.[37] Furthermore, the court found "no thread of logic" existed to prevent extending that right to an incompetent.[38] Thus, Karen's private right to terminate her non-cognitive life could not be discarded simply because her debilitated condition prevented a conscious exercise of that right.[39] Accordingly, the court next focused on the manner in which a grossly incompetent Karen could implement her right to discontinue treatment.[40]

RUTGERS L. REV. 243, 246 (1977).

34. 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

35. *Id.* at 25; 355 A.2d at 655. Although Karen was not "brain dead," she was comatose and suffered from decortication, a condition relative to brain derangement. *Id.* at 24, 355 A.2d at 654. Karen was placed on a respirator to assist her in breathing. *Id.*

36. *Id.* at 53, 355 A.2d at 670. The court ruled that Karen's father was a suitable guardian, and that the appointed guardian could choose attending physicians. *Id.* at 53-54, 355 A.2d at 670-71. Mr. Quinlan sought only termination of the respiration device and apparently had no intention of seeking to discontinue any other life-sustaining treatment such as antibiotics and intravenous feeding. *See* N.Y. Times, May 29, 1976, § 1, at 20, col. 5.

37. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663. The court stated that this right enunciated in *Griswold* is presumably "broad enough" to allow refusal of treatment "in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." *Id.*

38. *Id.* at 39, 355 A.2d at 663.

39. *Id.* at 41, 355 A.2d at 664. The court found that since:

> [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.

Id. The court distinguished this situation from its earlier decision in John F. Kennedy Mem. Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971). There a severely injured woman attempted to resist blood transfusions and surgery due to religious beliefs. The court found the woman to be apparently "savable to long life and vibrant health;—a situation not at all like the present case." *Quinlan*, 70 N.J. at 39, 355 A.2d at 663.

40. *Quinlan*, 70 N.J. at at 41, 355 A.2d at 664. The court stated:

> 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

Seeking the least burdensome procedure, the court permitted Karen's family to exercise its best judgment as to whether Karen, if capable, would reject extraordinary medical treatment. If, according to their substituted judgment,[41] Karen would choose to die naturally, the life-support systems could be removed. Before exercising such judgment, however, the court required family consultation with a hospital ethics committee and a medical determination that the comatose condition would continue.[42] In formulating this procedure, the court specifically rejected any requirement of judicial intervention in natural death decisions. The court recognized that judicial intervention would be an inappropriate encroachment upon the medical profession's field of competence.[43]

B. Extensions of Quinlan*—The Doctrine of Substituted Judgment*

Massachusetts first examined the passive euthanasia issue shortly after New Jersey's *Quinlan* decision. In *Superintendent of Belchertown State School v. Saikewicz*,[44] the elderly incompetent resided in a state mental health facility and suffered from severe mental retardation and leukemia.[45] With an I.Q. of ten and a mental age of less than three years, he was unable to understand his fatal illness.[46] Though chemotherapy was the accepted form of treatment, it offered no cure, and at best, only a thirteen month chance of remission.[47]

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weight.

Id.

41. The substituted judgment doctrine allows an incompetent patient's guardian to assert the patient's personal subjective right of privacy, if in the guardian's opinion, that patient would so assert it. *See id.*

42. If the right of privacy in treatment termination cases is analogous to abortion cases, then use of an ethics committee may be constitutionally suspect according to the Supreme Court's decision in Doe v. Bolton, 410 U.S. 179 (1979). *See* Comment, *supra* note 30, at 121.

43. *Quinlan*, 70 N.J. at 50, 355 A.2d at 669. *See* Relman, *The* Saikewicz *Decision: A Medical Viewpoint*, 4 AM. J.L. MED. 233, 235 (1978). Relman strongly disagrees with judicial resolution of natural death decisions, claiming that such a policy violates both common sense and clinical tradition and will result in serious problems such as prolongation of suffering. He therefore suggests that judicial input occur only when there is disagreement concerning treatment among next of kin or when a complaint is brought by a relevant party. *Id.*

44. 373 Mass. 728, 370 N.E.2d 417 (1977).

45. *Id.* at 729, 370 N.E.2d at 419.

46. *Id.* at 731, 370 N.E.2d at 420. Saikewicz was diagnosed as having acute myeloblastic leukemia. *Id.* at 729, 370 N.E.2d at 419. Because Saikewicz could communicate only by grunts and gestures, he was unable to indicate whether he was experiencing pain. *Id.* at 731, 370 N.E.2d at 420.

47. *Id.* at 732, 370 N.E.2d at 420. Even when administered, chemotherapy had only a 30% to 40% chance of causing remission of the disease. *Id.* at 753-55, 370 N.E.2d at 431-32. Furthermore, evidence indicated that there were toxic side effects to the treatment which included "pain and discomfort,. . .increased chance of infection, possible bladder irritation, and possible

Because Saikewicz was unable to give informed consent to treatment, the facility's superintendent petitioned the probate court to appoint a guardian ad litem authorized to make necessary medical decisions using "substituted judgment."[48] Comparing the rights of competent patients with those of incompetent patients, the court found the two classes possessed equivalent privacy rights based on the value of human dignity.[49] To decide otherwise would "downgrade the status of the incompetent person by placing a lesser value on his intrinsic worth and vitality."[50] The majority cited *Quinlan* to support its conclusion that the right of privacy encompassed Saikewicz' right to avoid unwanted infringment of his bodily integrity.[51]

In analyzing how *Saikewicz* could exercise this right to privacy, the Massachusetts court followed *Quinlan* and adopted a substituted judgment test.[52] The court, however, diverged from the *Quinlan* pro-

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loss of hair." *Id.* at 734, 370 N.E.2d at 421. Administration of the treatment would require Saikewicz' cooperation, yet doctors testified that his incompetent condition would mandate forcible restraint to prevent his tampering with intraveneous devices. Such restraint could increase pain and cause further complications such as penumonia. *Id.* at 734 n.5, 370 N.E.2d at 421 n.5.

48. *Id.* at 729, 370 N.E.2d at 419. The court states its basis for using substituted judgement in a footnote:

> In arriving at a philosophical rationale in support of a theory of substituted judgment in the context of organ transplants from incompetent persons, Professor Robertson of the University of Wisconsin Law School argued that "maintaining the integrity of the person means that we act toward him 'as we have reason to believe [he] would choose for [himself] if [he] were [capable] of reason and deciding raitonally.' It does not provide a license to impute to him preferences he never had or to ignore previous preferences. . . . If preferences are unknown, we must act with respect to the preferences a reasonable, competent person in the incompetent's situation would have." Robertson, Organ Donations by Incompetents and the Substituted Judgment Doctrine, 76 Colum. L. Rev. 48, 63 (1976), quoting J. Rawls, A Theory of Justice 209 (1971). In this way, the "free choice and moral dignity" of the incompetent person would be recognized. "Even if we were mistaken in ascertaining his preferences, the person [if he somehow became competent] could still agree that he had been fairly treated, if we had a good reason for thinking he - would have made the choices imputed to him." Robertson, *supra* at 63.

Saikewicz, 373 Mass. at 750-51 n.15, 370 N.E.2d at 430 n.15.

49. *Saikewicz*, 373 Mass. at 728, 739, 370 N.E.2d at 424 (1977). The court also recognized the "unwritten constitutional right of privacy found in the penumbra of specific guarantees of the Bill of Rights." *Id.* The trend in the law has been to give incompetent person the same rights as other individuals. Boyd v. Registrars of Voters of Belchertown, 368 Mass. 632, 334 N.E.2d 629 (1975).

50. *Saikewicz*, 373 Mass. at 747, 370 N.E.2d at 428.

51. *Id.* at 739, 370 N.E.2d at 424 (1977), (citing *In re* Quinlan, 70 N.J. 10, 355 A.2d 657, *cert. denied*, 429 U.S. 922 (1976)). *See, e.g.*, Reddington v. Clayman, 334 Mass. 244, 134 N.E.2d 920 (1956) (holding defendant in malpractice suit who performs nonconsensual surgery liable for at least nominal damages due to invasion of privacy). *See generally* Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973).

52. *Saikewicz*, 373 Mass. at 750, N.E.2d at 430 (1977).

cedure for implementing this test.[53] Unlike Karen, Saikewicz had always been incompetent and had never possessed the ability to make known his personal preference for life or death. For this reason, the court decided Saikewicz's choice could best be made by the judiciary.[54] This judicial intervention requirement subsequently generated enormous concern among the Massachusetts medical guild. Uncertain about possible liability for removal of life-sustaining equipment, physicians sought judicial approval of even routine medical decisions.[55]

Recently, however, the Massachusetts Supreme Court clarified its stance concerning the need for judicial involvement in substituted judgment cases.[56] Presently, court approval is required only where no caring family members are available to substitute their judgment on behalf of the incompetent, or where the patient has never been able to express his preference for life or death.[57] Since the incompetent patient who has previously executed a valid living will[58] has articu-

53. *Id.* at 759, 370 N.E.2d at 435 (1977). *But see* Annas, *Reconciling* Quinlan *and* Saikewicz: *Decision Making for the Terminally Ill-Incompetent*, 4 AM. J.L. & MED. 367 (1979). Annas attacks the assumption that *Saikewicz*, by virtue of its judicialization approach, directly contradicts *Quinlan*. *Id.* at 371-85. According to his proposition, the *Quinlan* court simply viewed Quinlan's situation as one in which a hopeless medical prognosis left no doubt that Karen would have chosen death. The *Saikewicz* court, on the other hand, possessed legitimate doubt as to the patient's true desires, doubt that could best be resolved through adversary proceedings. *Id.* at 375-76. Together, the *Quinlan* and *Saikewicz* decisions delineate, in Annas' view, the appropriate spheres of medical and legal decision making. *Id.* at 384. -

54. *Saikewicz*, 373 Mass. at 759, 370 N.E.2d at 435 (1977). According to the court, such questions of life and death required the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. *Id.* The *Saikewicz* holding has been roundly criticized in the medical community. *See, e.g.*, Relman, *supra* note 43.

55. *See* In the Matter of Dinnerstein, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978). Sixty-six year old Dinnerstein was diagnosed as having Alzheimer's disease, an incurable condition that destroys brain tissue. *Id.* at 467, 380 N.E.2d at 134. At the time of the trial, the patient was in a vegetative state, immobile, speechless and unable to swallow without choking. Her life expectancy was no more than a year. *Id.* at 468, 380 N.E.2d at 135. Due to her condition, the treating physician anticipated cardiac or respiratory arrest at any time. The physician sought court approval of his recommendation that resuscitation efforts not be taken in the event of cardiac or respiratory arrest. *Id.* The court found that the question was entirely within the competence of the treating physician and it could not be answered by judicial decision. *Id.* at 475, 380 N.E.2d at 139.

56. *See* In Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980).

57. *Compare* In Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982) (requiring judicial intervention where no family members are available for consultation) *with* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (requiring court participation where patient was never able to express his preference for life or death).

58. Whether a living will is "valid" depends upon statutory requirements in those states with Natural Death Acts. *See infra* notes 173-76 and accompanying text. In Florida, the Fourth District Court of Appeal has asserted that a valid living will is one executed by a mentally sound patient, and duly proved by at least one disinterested witness. J.F.K. Mem. Hosp. Inc. v. Bludworth, 432 So. 2d 611, 620 (Fla. 4th D.C.A. 1983).

lated his desires, Massachusetts' rationale would not mandate judicial intervention in the decision to terminate treatment. Other states addressing the matter of substituted judgment have likewise determined that judicial intervention is not required.[59] Though the states' highest courts have yet to confront a petition for implementation of a living will,[60] two states have rendered decisions in closely analogous situations.

C. Personal Determination Without Judicial Intervention

In *In re Storar*,[61] New York's highest court considered how an incompetent with a known natural death desire could implement his right to privacy. While in surgery, Brother Joseph Fox suffered cardiac arrest resulting in permanent brain damage.[62] Previously, Brother Fox had participated in formal discussions regarding the official position of the Roman Catholic Church on the moral implications of the *Quinlan* decision.[63] The discussions revealed that the Church approved of terminating extraordinary life-support systems when no reasonable hope of recovery existed.[64] Brother Fox agreed with Church officials and unequivocally stated that he would not want extraordinary means used to prolong his life.[65] He reiterated this desire while competent less than two months before his final hospitalization.[66]

Faced with a petition to remove Brother Fox's life-support system, the Appellate Division of the Supreme Court of New York held

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59. *See infra* note 165.

60. The Florida Supreme Court has accepted certiorari in the living will case of J.F.K. Mem. Hosp. v. Bludworth, 432 So. 2d 611 (Fla. 4th D.C.A. 1983). *See infra* text accompanying notes 99-121.

61. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), *modifying* Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980).

62. *Storar*, at 371, 420 N.E.2d at 67, 438 N.Y.S.2d at 269. Brother Fox lost the ability to breathe spontaneously and doctors placed him on a respirator which maintained him in a vegetative state. *Id.*

63. *Id.* at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

64. *Id.* The Vatican issued formal declarations in 1957, wherein Pope Pius XII stressed that no obligation exists for an individual to use extraordinary means to prolong life. Though finding it incumbent that the physician take all ordinary means to restore vital functions and consciousness, the Pope stated that "it is not obligatory, however, to continue to use extraordinary means indefinitely in hopeless cases, but normally one is held to use only ordinary means . . . that do not involve any grave burden for oneself or another. There comes a time when resuscitative efforts should stop and death be unopposed." Pope Pius XII, Prolongation of Life, 4 AM. Q. PAPAL DOCTRINE 393 (1958). More recent statements express the same opinion: "When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life. . . ." Vatican's Declaration on Euthanasia, May 5, 1980, at 8.

65. Storar, 52 N.Y.2d at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

66. *Id.*

that Brother Fox had a constitutional right to discontinue use of extraordinary medical treatment.[67] The court followed the *Saikewicz* approach requiring judicial approval before that right could be exercised.[68] The court also established an elaborate procedure to be followed by medical personnel, family members, and the judiciary before allowing termination of treatment.[69]

On appeal, the New York Supreme Court reversed this requirement of judicial intervention.[70] The court concluded that Brother Fox had a common law right to determine what to do with his body which could not be forfeited upon his losing competency.[71] Furthermore, the court refused to address the contention that this right was personal and could not be exercised by a third party after the patient became incompetent.[72] Based on statements made prior to his incompetency, the court recognized that Brother Fox made the decision for himself.[73] According to the court, Brother Fox had carefully reflected on the subject and expressed his desire not to prolong his life by medical means if he became terminally ill.[74] Based on this clear expression of intent,[75] the New York court held that Brother Fox's directive could be implemented without prior court assessment.[76]

In a similar situation, the Florida Supreme Court agreed that a competent terminally ill adult has the right to halt life-prolonging treatment.[77] In *Satz v. Perlmutter*,[78] the patient sought judicial ap-

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67. Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *modified, In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

68. Eichner v. Dillon, 73 A.D.2d 431, 459, 426 N.Y.S.2d 517, 539 (1980).

69. *Id.* at 476-77, 426 N.Y.S.2d at 550. According to the court, the attending physician must first certify that the patient is terminally ill and comatose. Thereafter, someone close to the patient must present the prognosis to a hospital committee for confirmation. Upon confirmation, the patient's representative must apply to the court for appointment as "the committee of the incompetent." The district attorney must then receive notice. Additionally, a guardian ad litem must be appointed to assure the patient's protection by a neutral party. *Id.*

70. *Storar*, 52 N.Y.2d at 372, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.

71. *Id.* at 378-79, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

72. *Id.* at 378-79, 420 N.E.2d at 71-72, 438 N.Y.S.2d at 274.

73. *Id.*

74. *Id.* The court noted that Brother Fox's iterated desires were "obviously solemn pronouncements and not casual remarks." *Id. Cf. In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976).

75. *Storar*, 52 N.Y.2d at 379, 420 N.E.2d 72, 438 N.Y.S.2d at 274. Most courts considering termination of medical treatment have utilized a clear and convincing evidentiary standard forbidding relief whenever evidence is loose, equivocal or contradictory. *See, e.g.*, Leach v. Akron Gen. Med. Center, 68 Ohio Misc. 1, 12, 426 N.E.2d 809, 816 (Ct. C.P., Prob. Div. 1980) (allowing removal of a respirator from a terminally ill incompetent upon clear and convincing evidence that patient would desire such action).

76. *Id.* at 383, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.

77. Satz v. Perlmutter, 362 So. 2d 160 (4th D.C.A. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

78. *Id. Perlmutter* has received widespread discussion and analysis. *See* Note, *In re Living Will*, 5 NOVA L. REV. 445 (1981); Comment, *Florida's Right to Die, supra* note 30; Comment, *Who Will Decide When a Patient May Die?*, 32 U. FLA. L. REV. 808 (1981); Comment,

proval of his decision to discontinue extraordinary medical treatment.[79] Seventy-three year old Perlmutter suffered from Lou Gerhig's disease,[80] an incurable condition with a life-expectancy of two years from the time of diagnosis.[81] In great pain and with only months left to live, Perlmutter petitioned the circuit court for removal of the mechanical respirator attached to his trachea.[82] Fully competent and aware that removal of the respirator would reduce his life-expectancy to less than an hour,[83] Perlmutter testified at a bedside hearing that "[death] can't be worse than what I'm going through now."[84]

Adopting the reasoning of *Quinlan*, the trial court acknowledged that the constitutional right of privacy encompassed the right to decline medical treatment.[85] Because he was competent and could make an informed decision, the court found Perlmutter's right to privacy even more compelling than Quinlan's right.[86] The court concluded that the interests of the state,[87] the medical profession,[88] and third parties[89] did not outweigh Perlmutter's right to natural death.

Affirming the trial court,[90] the Fourth District Court of Appeal allowed termination and elaborated on the lower court's analysis of valid state interests.[91] Following the *Saikewicz* rationale, the court recognized four specific state interests that might outweigh a terminally ill patient's right to die. These interests include preserving life, protecting innocent third parties, preventing suicide, and maintaining the medical profession's ethical integrity.[92] The court concluded these interests did not preclude Perlmutter from refusing medical

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Satz v. Permutter: *A Constitutional Right to Die?*, 35 U. MIAMI L. REV. 377 (1981).

79. Extraordinary treatment is commonly defined as "all medicines, treatments and operations which can not be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit." Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723, 736 (1973).

80. *Perlmutter*, 362 So. 2d at 161 (Fla. 4th D.C.A. 1978). Amytrophic lateral sclerosis, commonly known as Lou Gehrig's disease, is a degenerative condition of the neurological system causing paralysis and eventually death. *Id.*

81. *Id.*

82. *Id.* On several occasions, Perlmutter had attempted to remove the respirator, but hospital personnel were notified by an alarm and prevented his actions. *Id.*

83. *Id.*

84. *Id.* at 161.

85. Perlmutter v. Florida Med. Center, 47 Fla. Supp. 190, 194 (Broward County Cir. Ct. 1978).

86. *Id.* at 193.

87. *See infra* text accompanying notes 127-30.

88. *See infra* text accompanying notes 137-50.

89. *See infra* notes 131-32 and accompanying text.

90. *Perlmutter*, 362 So. 2d 160 (4th D.C.A. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

91. *Id.* at 162. *See infra* note 92 and accompanying text.

92. *Id.*

treatment.[93] Rather, the district court agreed with *Saikewicz*,[94] and distinguished the state's interest in saving human life from that of merely extending the life of a terminally ill patient.[95] On certiorari, the Florida Supreme Court affirmed *Perlmutter*[96] and expressly adopted the district court opinion.[97] The court, however, confined its decision to the instant facts, leaving complex legal, medical, and social issues unanswered pending legislative action.[98]

D. The Written Directive—An Incompetent's Personal Choice

Florida recently confronted a case of first impression concerning implementation of a living will in *John F. Kennedy Memorial Hospital v. Bludworth*.[99] Several of the previously discussed decisions involving terminally ill incompetents have dealt with substituted judgment, where the incompetent's desire to live or die was discernable only through the opinion of someone close to the dying patient.[100] Unlike those cases, the desires of the incompetent terminally ill patient in *J.F.K. Memorial Hospital* was clearly articulated in his living will.[101] This duly executed living will expressed Frances B. Landy's directive that his life not be prolonged by artificial means,[102] and that

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93. *Id.*

94. *Id.* at 162. When treatment is lifesaving as distinct from life prolonging, the state's interest in the preservation of life prevails. *See In re* President & Dir. of Georgetown Col., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). This interest weakens, however, in situations where continued treatment serves only to prolong a life inflicted with incurable conditions. *See In re* Quinlan, 70 N.J. 41, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

95. *Perlmutter*, 362 So. 2d at 162.

96. Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980).

97. *Id.* at 360.

98. *Id. Cf.* Dade Cty. Classroom Teachers' Ass'n v. Ryan, 225 So. 2d 903 (Fla. 1969). There, the Florida Supreme Court urged the legislature to enact standards for implementing a newly acknowledged right for teachers collectively bargaining. After four years of legislative inaction, the Teachers' Association petitioned the court to appoint a commission to recommend bargaining guidelines. Dade Cty. Classroom Teachers' Ass'n v. Legislature, 269 So. 2d 684 (Fla. 1972). The court refused to make such an appointment unless the legislature refused to act within a reasonable time. *Id.* at 688. In 1973, when the Legislature again refused to act, the court stepped in and appointed a commission. Finally, six years after judicial recognition of this right, the legislature implemented an appropriate provision. *See* McHugh, *The Florida Experience in Public Employee Collective Bargaining, 1974-1978: Bellwether for the South*, 1 FLA. ST. U.L. REV. 263 (1978). *See also supra* note 30, at 104.

99. 432 So. 2d 611 (Fla. 4th D.C.A 1983). Research has revealed no other reported case concerning implementation of a living will.

100. Assertion of an individual's desire in a valid living will avoids hearsay problems and is therefore more indicative of that person's choice than ascertainment through substituted judgment.

101. "Patient's Instructions to Physicians and Medical Care Provider to Terminate Medical Treatment," Plaintiff's Complaint, Exhibit 1 (Apr. 16, 1975) at 3.

102. *Id.* Landy's will fails to define "artificial means." It therefore may be interpreted to request that no medical procedures be undertaken, whether classified as extraordinary or routine. Arguably, the language could be interpreted to prohibit any medical treatment and to

he be allowed to die without pain and with dignity.[103]

While hospitalized, Landy became terminally ill and lapsed into a comma.[104] As soon as Landy was placed on a mechanical respirator,[105] Mrs. Landy presented the treating physician with a copy of his living will.[106] Though Mrs. Landy continually urged the physician to remove artificial life-support in accordance with her husband's directive, her pleas were refused.[107] In view of potential civil[108] and criminal[109] liability, the hospital and doctor filed an action seeking declaratory relief.[110] Landy died before this request was examined.[111] Because the hospital is regularly requested to remove life support systems,[112] the action was continued to obtain judicial guidance.[113] The hospital contended that court approval was unnecessary for the removal of extraordinary support systems from a terminally ill patient.[114] Unpersuaded, the trial court held that a guardian must be appointed and a court order obtained before relief from liability

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allow only the administration of drugs which would hasten death. *See* Answer Brief of Respondent at 2, 6, J.F.K. Mem. Hosp. v. Bludworth, 432 So. 2d 611 (Fla. 4th D.C.A. 1983).

The Fourth District Court of Appeal, however, defined "life sustaining procedures" and evidently held Landy's words to evince the same meaning. *See* 432 So. 2d at 619.

103. Though Mr. Landy was comatose, evidence indicated that he was experiencing pain. His treating physician testified as to the "irritating" and "damaging" nature of placing a tube down his throat. *See* Petitioner's Brief on the Merits at 2, J.F.K. Mem. Hosp. v. Bludworth, 432 So. 2d (Fla. 4th D.C.A. 1983).

104. 432 So. 2d at 613-14.

105. At the time physicians placed Landy on the respirator, his heart was malfunctioning, his lungs were filled with fluid, and he had chronic interstitial fibrosis and gastrointestinal bleeding. Petitioner's Brief on the Merits at 2, 432 So. 2d 611 (Fla. 4th D.C.A. 1983).

106. 432 So. 2d at 614.

107. *Id.*

108. The doctrine of informed consent mandates that physicians obtain the patient's consent to any treatment prior to its administration. *See* Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977); Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413.

109. Though commentators have written much about the criminal consequences of passive euthanasia, no case involving a physician's termination of a terminally ill's life-prolonging treatment has gone to trial. Collester, *supra* note 2, at 310. *But see id.* at 312-22 (discussing criminal liability in the case of active euthanasia).

110. 432 So. 2d at 614.

111. *Id.*

112. At trial, the hospital's administrator testified that relatives of terminally ill patients frequently requested the removal of life sustaining treatment. In response, the hospital always required a court order authorizing removal, but in *every case* the patient expired prior to securing the order. Main Brief of Appellants, at 6, 432 So. 2d 611 (Fla. 4th D.C.A. 1983) (emphasis added). At the time of trial, forty terminally ill incompetent patients remained at the hospital. 432 So. 2d at 614.

113. 432 So. 2d at 614. The trial court correctly held that since the controversy was one likely to recur yet again evade review, the issue presented was justiciable. *Id. See, e.g.*, Roe v. Wade, 410 U.S. 113, 125 (1973); Times Pub. Co. v. Burke, 375 So. 2d 297 (Fla. 2d D.C.A. 1979).

114. 432 So. 2d at 614.

would be granted for removing the life-support system.[115]

In affirming the trial court's judgment, the Fourth District Court of Appeal specifically recognized Landy's constitutionally protected right to discontinue life-prolonging treatment.[116] In determining the proper procedure to best implement this right, the court distinguished its earlier holding in *Perlmutter*.[117] The majority asserted that in *Perlmutter*, the patient himself directly benefited from his death with dignity request, while in *J.F.K. Memorial Hospital*, the direct beneficiaries were Landy's family members.[118] As a result of of this distinction, the court shifted its focus from safeguarding state interests to protecting the interests of the terminally ill comatose individual.[119] Consequently, the district court held that implementation of a comatose individual's right to terminate medical treatment required judicial review.[120] Finally, the court certified the question to the Florida Supreme Court as one of great public interest.[121]

III. Judicial Encroachment—Florida's Non-Compelling Invasion of Incompetents' Rights

All states addressing the issue clearly find that a competent or incompetent terminally ill adult has a constitutional right to refuse or discontinue extraordinary medical treatment.[122] The question of

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115. *Id.* at 611.

116. *Id.* at 618-19.

117. *Id.* at 617-18.

118. *Id.* at 618. In *Perlmutter*, according to the court, "there was a present expressed intent by a mentally incompetent individual to be allowed to die with dignity. The individual himself was the direct beneficiary of the request and the benefit was cessation of pain and suffering." *Id.* In *J.F.K. Memorial Hospital*, the court assumed, philosophical considerations aside, that "in the case of a comatose individual there is no pain and suffering." *Id.* The court reasoned that the direct benefits of termination in such a case were "financial savings and cessation of emotional drain," with the beneficiaries being family members and not the patient himself. *Id. But see supra* note 103. *See also* Page, *The Pain of Terminal Illness and Bereavment and Approaches to It*, 28 Cent. Afr. J. Med. 257-61 (1982) (discussing pain suffered by terminally ill patients, including comatose individuals).

119. 432 So. 2d at 618.

120. *Id.* at 619

121. *Id.* at 620. The court asked:

> In the case of a comatose and terminally ill individual who has executed a so-called "living" or "mercy" will, is it necessary that a court appointed guardian of his person obtain the approval of a court of competent jurisdiction before terminating extraordinary life support systems in order for consenting family members, the attending physicians, and the hospital and its administrators to be relieved of civil and criminal liability.

Id. at 620.

122. *Id.* at 614. To date, only six states have addressed the question of mandatory treatment of a terminally ill incompetent. *See* Severns v. Wilmington Med. Center, 421 A.2d 1334 (Del. 1980); Superintendent of Belchertown School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976); *In re*

whether this right encompasses freedom from judicial intrusion, however, is not as apparent and has been answered in the negative by one court.[123] Though both competents and incompetents possess a constitutional privacy right, Florida law requires judicial intervention only for incompetents.[124] Gauged against standards set in United States Supreme Court privacy decisions,[125] this mandatory judicial intervention is constitutionally suspect. State regulation of a patient's right to die must be strictly justified by a compelling state interest.[126] Close scrutiny of Florida's asserted state interests reveals their uncompelling nature in the case of terminally ill incompetents. Thus, despite these state interests, judicial approval should not be required.

The Florida Supreme Court held the state's interest in saving human life is distinct from an interest in temporarily prolonging a terminally ill individual's nonproductive life.[127] While the interest in saving life is compelling, the compelling quality wanes as the patient's chances for recovery diminish.[128] Even fear of foul play fails to justify the court's interference[129] since an expedited hearing brought by a guardian would do little to uncover bad faith efforts to terminate an incompetent's treatment.[130]

Likewise, the state's interest in protecting third parties is not so

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Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); Leach v. Arkron Gen. Med. Center, 68 Ohio Misc. 1, 49, 426 N.E.2d 809 (Ohio Com. Pls. 1981); *In re* Coyler, 99 Wash. 2d 114, 660 P.2d 738 (1983).

123. *See J.F.K. Memorial Hospital*, 432 So. 2d 611 (Fla. 4th D.C.A. 1983). In analyzing decisions from the "only five states" that have addressed the issue, the *J.F.K. Memorial Hospital* court failed to note the most recent decision on the issue by Washington's Supreme Court. In *In re Coyler*, the incompetent patient suffered massive brain damage and became comatose. Like the courts before it, the Supreme Court of Washington recognized a patient's right to determine his own medical destiny, stating that "the question is,. . .who may exercise an incompetent's right to refuse life sustaining treatment if no directive exists." *In re* Coyler, 99 Wash. 2d 114, 124, 660 P.2d 738, 744 (1983).

After comparing *Quinlan* and *Saikewicz*, the court opted for the *Quinlan* approach, holding that judicial intervention is not required in every decision involving withdrawal of life-sustaining medical treatment. *Id.* at 125-27, 660 P.2d at 744-46. Pointing out that Coyler had been competent prior to her illness and that she had family members willing to attest to her beliefs, the court rejected the *Saikewicz* approach, finding judicial involvement unresponsive and cumbersome. *Id.* at 127, 660 P. 2d at 745-46. The decision, however, was expressly limited to "the removal of life sustaining systems from an incurable patient," and did not encompass the propriety of withdrawing curative treatment from an incompetent patient, even if that patient is terminally ill. *Id.* at 139, 660 P.2d at 751-52.

124. *See* Satz v. Perlmutter, 362 So. 2d 160 (4th D.C.A. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980). *Cf.* J.F.K. Mem. Hosp. v. Bludworth, 432 So. 2d 611 (Fla. 4th D.C.A. 1983).

125. *See supra* text accompanying notes 16-33.

126. *Id.*

127. Satz v. Perlmutter, 362 So. 2d 160, 162 (4th D.C.A. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

128. *Id.*

129. *Contra, id.* at 618.

130. *See supra* note 112.

compelling as to justify a burdensome courtroom hearing. Where a patient has executed a living will specifically asserting his right of privacy, the state may not override this directive with a third party protection claim.[131] In cases such as *J.F.K. Memorial Hospital*, where no minor children need protection, the state cannot claim a compelling need for judicial intervention.[132]

An interest in preventing suicide also fails to compel judicial intervention. Death resulting from failure to employ life-support systems on a terminally ill patient is death from natural causes.[133] A patient resisting medical treatment is not intent on repudiating life, but on avoiding a prolonged, undignified dying process. There is no assault on the body or active destruction of life; natural processes are simply allowed to run their course without artificial disruption.[134] Since the patient neither sets the death process in motion nor desires to die,[135] the state's interest is minimal.

Finally, the state's interest in maintaining the ethical integrity of the medical profession also falls short of compelling. Prevailing medical ethics do not require prolongation of life for a terminally ill comatose patient.[136] Indeed, institutional considerations weigh heavily

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131. The state's interest in protection of third parties has prevailed over individual freedom of choice in medical consent cases when dependent children are involved. Where an adult's refusal of treatment could impose a financial burden on society due to children who might become wards of the state, the courts have usually interceded and ordered medical care. *See In re* President & Dir. of Georgetown Col., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). There, the court authorized a hospital to administer blood transfusions to a Jehovah's Witness who had a seven-month-old son but was unwilling to consent to treatment. *Id.* at 1006. Judge Skelly Wright discussed valid state considerations concerning loss of parental care, guidance, and a duty to the community to care for small children. *Id.* at 1008.

132. When no burden will be placed upon the state to care for dependents, an adult's decision to refuse medical treatment is almost always sanctioned by the court when challenged. *See* A. HOLDER, MEDICAL MALPRACTICE LAW 16, 36 (1975); *but see* John F. Kennedy Mem. Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971).

133. *Perlmutter*, 362 So. 2d at 162.

134. In 1974, testimony before a Senate Subcommittee pointed out that "about ¾ of American physicians say they practice 'passive' euthanasia regularly—that is, the withdrawal of artificial life support and permit dying." *Medical Ethics: The Right to Survival: Hearings Before the Subcommittee on Health of the Comm. on Labor and Public Welfare*, 93 Cong., 2d Sess. 9 (1974).

135. Though the patient "consents" to death by choosing to cease life-prolonging treatment, he does not choose to be terminally ill. At least one author alleges that in the case of brain-stem-damage patients, physicians regularly practice *involuntary* passive euthanasia, in which treatment is withheld without a patient's consent, though this arguably constitutes culpable homicide. *See* Note, *supra* note 4, at 1277.

136. Almost all authority is in agreement that prolongation of life is not always desirable. *See, e.g.*, Baron, *Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litum in* Saikewicz-*type Cases*, 4 AM. J.L. & MED. 111 (1978); Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. & MED. 337 (1979); Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling* Saikewicz-*type Cases*, 5 AM. J.L. MED. 97 (1979). *See also* Gold, *Wiser than the Laws?:*

against preserving an incapacitated individual's life against his will.[137] Though physicians have traditionally been responsible for determining the nature, extent, and duration of medical treatment,[138] the physician's duty to cure or prevent disease does not mandate unnecessary prolongation of life.[139] No categorical imperative exists which requires doctors to aggressively treat all terminal illness; rather, doctors must weigh treatment benefits against disadvantages to the patient.[140] Routine judicialization of the physician-patient relationship is not only unconstitutionally burdensome, but may also be counterproductive for at least two reasons.

First, the shifting and subtle complexities of clinical situations make a courtroom decision impractical.[141] A patient's medical condition often changes so quickly that emergency medical decisions cannot wait for even an expedited judicial hearing.[142] The courts cannot be expected to exercise sound medical judgment, nor can they act promptly and flexibly to meet rapidly changing medical needs.[143]

Secondly, imposing expensive, mandatory judicial proceedings

The Legal Accountability of the Medical Profession, 7 AM. J.L. & MED. 145 (1981).

137. Indefinite maintenance of terminally ill incompetents could easily over-tax hospital facilities, thereby depriving patients with better prognoses from obtaining intensive care. Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of* In re Quinlan, 30 RUTGERS L. REV. 267, 297 (1977). Furthermore, the economical cost of sustaining some terminally ill incompetents may be too straining on society's limited resources. *See Death with Dignity: An Inquiry into Related Public Issues; Hearings Before the Special Comm. on Aging, U.S. Senate*, 92d Cong., 2d Sess. 29 (1972) (statement of Dr. Walter W. Sackett, member Florida House of Representatives). Dr. Sackett testified before the committee concerning Florida's 1500 severely retarded patients:

> According to present-day cost and the fact that you can keep these individuals alive artificially to between [ages] 50 to 60, it's going to cost the State of Florida for 50 years $5 billion. . . . Translated roughly this means it's going to cost the various States over this same period over $100 billion. . . .

Id. at 30.

138. *See generally* Zimring, *supra* note 4, at 951.

139. *See generally* Zimring, *When is the Physician Playing God?*, 28 T.A. GERIATRIC SOC. 419 (1980).

140. *See, e.g.*, Am. Med. News, July 26, 1976, at 11, col. 1, discussing the *Saikewicz* case. At trial, a cancer specialist testified that the proper course to take in regards to chemotherapy administration was not clear-cut since the treatment, if successful, would only temporarily arrest the disease. Moreover, the treatment's side effects include vomiting and nausea, bladder irritation, and numbness of the extremities. *Id.*

141. *See* Relman, *supra* note 53, at 240.

142. *Id.*

143. *Id.* An examination of medical litigation is exemplary. In Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *modified*, *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), the lower court took almost two years to decide the case. A year before it reached its decision, the patient died of congestive heart failure despite the assistance of a respirator. Similarly, a final decision in *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980), required almost two years and again the patient died prior to its issuance due to a disease not associated with his terminal condition.

may lead to "closet"[144] decisions in incompetent terminally ill cases. Though the number of potential cases involving life-prolonging decisions is huge,[145] few have reached the courts. The lack of judicial guidance has caused widespread confusion in the medical profession. As a consequence many physicians may choose either to prolong life irrespective of the patient's desire, or to closet decisions without discussion or legal approval.[146] "No treatment" or "withdrawal of treatment" decisions are made constantly, but are rarely brought to judicial attention.[147] Neither relatives nor physicians want to undertake the trouble or expense of obtaining judicial approval, particularly when they have no guarantee the court's judgment will better reflect the correct medical or ethical decision. A grieving family will likely be hesitant to undergo an adversarial courtroom proceeding and the treating physician may be hardpressed to enter the judicial arena due to time restraints and economic considerations.[148]

The state, too, will be overwhelmingly burdened by constant petitions to assert death with dignity. Unless additional staffing is allocated, prosecutors will be unable to perform in-depth investigations for every case. Consequently, the judicial purpose of safeguarding against foul play will be negated. Overall, physicians may perceive a mandatory courtroom procedure as a confusing bureaucratic encroachment on their decisionmaking powers.[149] Thus, judgments previously made after full and explicit consultations will be made hastily and even furtively, thereby eliminating fruitful discussion.[150]

Although Florida explicitly recognizes an individual's right to privacy may be asserted in a natural death situation, it unnecessarily forces judicial intervention in the case of a terminally ill incompetent. This is true even if the incompetent's choice is clearly ascertainable through a living will.[151] Such a procedure obliterates the incompetent's panoply of rights merely because the patient can no longer sense the violation of those rights.[152] Rather, a competent, terminally ill person should be able to choose to terminate treatment and have that choice honored even if he later becomes incompetent.[153]

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144. *See* Relman, *supra* note 43, at 241.
145. *See, e.g., supra* note 112.
146. *See* Relman, *supra* note 43, at 241; *but see* Hudson, *Medical Ethics After* Quinlan, J. KAN. MED. SOC. May 1983, at 371.
147. *See supra* note 2.
148. *See generally* Cameron, *Terminal Care: Evaluation of Effects on Surviving Family of Care Before and After Bereavement*, 59 POSTGRAD. MED. J. 73-78 (1983).
149. *See, e.g.*, Annas, *supra* note 52.
150. *See* Relman, *supra* note 1, at 509.
151. *See* J.F.K. Mem. Hosp. v. Bludworth, 432 So. 2d 611 (Fla. 4th D.C.A. 1983).
152. Note, *supra* note 2, at 251.
153. *Id.*

Thus, Florida must act to guarantee that all its citizens, including competents who later become incompetent, can assert their fundamental right to privacy in terminally ill situations. A procedure must be devised to prevent the state from abridging its citizens' privacy rights with routine judicial intervention. As noted by the Florida Supreme Court in *Perlmutter*, this issue, containing complex legal, medical, and social values,[154] is best addressed in a legislative forum where factfinding is less confined and the interests of all parties are considered.[155] Recognizing this need for legislative action, numerous states have enacted natural death statutes.[156] Though Florida's legislature has considered the issue, it has failed over a dozen times to adopt suitable legislation.[157]

A. The Need For Judicial Action

Acknowledging the Florida legislature's failure to resolve the issue, the *Perlmutter* court held that preference for legislative treatment cannot shackle the courts when legally protected interests are at stake.[158] Legislative inaction must not bar court access to citizens who assert cognizable constitutional rights.[159] The Florida Supreme Court will soon consider this issue of whether a terminally ill incompetent who previously executed a living will must obtain court approval before terminating extraordinary treatment.[160]

The Supreme Court should follow the lead of states that currently have natural death statutes and permit implementation of an adult's living will without an appointed guardian or court approval.[161] While

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154. *Perlmutter*, 379 So. 2d at 360.

155. *Id.*

156. States with Natural Death Acts include: Arkansas, California, Delaware, Idaho, Kansas, Nevada, New Mexico, North Carolina, Oregon, Texas, Vermont, Virginia, and Washington.

157. Natural death bills were introduced in the Florida legislature every year from 1969 to 1982. *See, e.g.*, FLA. H.R. 91 (1st Reg. Sess. 1969, introduced by Rep. Sackett); FLA. S. (Reg. Sess. 1982, introduced by Rep. Childers). No bill was introduced in 1983.

158. *Perlmutter*, 379 So. 2d at 360.

159. *See supra* note 98.

160. 432 So. 2d at 620. In 1980, lawmakers amended the Florida Constitution to establish an individual right of privacy. FLA. CONST. art. I, § 23 (1980). Thus, Florida affirmed its belief that the state should guarantee this broad and fundamental right to its citizens. The *J.F.K. Memorial Hospital* majority recognized that this provision granted Florida citizens an explicit privacy right. The court consequently felt "duty bound" to protect this right and the "concomitant right to die with dignity" by setting forth a lengthy and complex procedure. 432 So. 2d at 619-20.

161. ARK. STAT. ANN. § 82-3801-04 (1981); CAL. HEALTH & SAFETY CODE § 7185-95 (West Cum. Supp. 1979-80); DEL. CODE ANN. tit. 16, § 250-09 (1982); IDAHO CODE § 39-4501-08 (1982); KAN. STAT. ANN. §§ 65-28, 101-109 (1980); NEV. REV. STATS. § 449.540-610 (1979); N.M. STAT. ANN. § 24-7.1-7,11 (1978); N.C. GEN. STAT. § 90,320-23; OR. REV. STAT. §§ 87,050-141 (1981); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon 1982); VT. STAT. ANN. tit. 18, § 5251-5262 (1983); WASH. REV. CODE ANN. § 70.122.010-.905 (1982).

some statutes are elaborate[162] and others are brief,[163] all delienate procedures that do not require routine judicial scrutinization.

These statutes recognize that individuals have a constitutional right to control decisions relating to their medical care.[164] Under these statutes, family members, physicians, and hospitals that follow the statutory procedures are relieved of any civil or criminal liability. A majority of the states specify the language to be used in the individual's directive.[165] The directive must clearly show the declarant's desire to avoid artificial, extraordinary, or extreme medical procedures calculated to prolong life.[166]

Each state legislature was undoubtedly cognizant of the state's interest in determining that a living will was actually executed by the declarant while of sound mind.[167] Indeed, these legislative enactments are drafted in contemplation of certain state interests. In considering the state interests, however, every state legislature determined that simple procedures ensured the trustworthiness of the written directive, and they deemed court approval unnecessary.

B. Implementation Without Intervention—Model Guidelines

Guided by the living will statutes of other states, Florida should

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162. *See, e.g.*, CAL. HEALTH & SAFETY CODE §§ 7185-95 (West. Cum. Supp. 1979-80). California was the first state to enact natural death laws.

163. *See, e.g.*, ARK. STAT. ANN. § 82-3802 (1981).

164. *See, e.g.*, DEL. CODE ANN. tit. 16, § 2502(a) (1982) stating: "An individual, legally adult who is competent and of sound mind, has the right to refuse medical or surgical treatment. . . ." *Id.*

165. States which specify directive language include: California, Idaho, Nevada, Oregon, and Texas. Virginia suggests a format, but does not make it mandatory.

166. *See, e.g.*, ARK. STAT. ANN. § 82-3802 (1981).

167. *See, e.g.*, N.M. STAT. ANN. § 24-7-3 (1978), stating:

> A. An individual of sound mind and having reached the age of majority may execute a document directing that if he is ever certified under the Right to Die Act (N.M. Stat. Ann. § 24-7-1 to 24-7-11 (1978)) as suffering from a terminal illness then maintenance medical treatment shall not be utilized for the prolongation of his life.
>
> B. A document described in Subsection A of this section is not valid unless it has been executed with the same formalities as required of a valid will pursuant to the provisions of the Probate Code.

Id. At least ten states require that the declarant be an adult of sound mind. These states are Alaska, California, Delaware, Washington, D.C., Illinois, Kansas, New Mexico, Oregon, Texas, Vermont and Washington. Arkansas and New Mexico permit another to execute the directive on behalf of a minor. Arkansas permits the directive to be made by another on behalf of those who are unable to do so because they are physically or mentally unable. North Carolina allows any declarant of sound mind to execute the directive, regardless of age. Idaho requires that the declarant be a "qualified patient, a person of sound mind at least eighteen (18) years of age diagnosed by the attending physician to be afflicted with a terminal condition." IDAHO CODE § 39-4503 (1982).

authorize a procedure following these basic guidelines:[168]

> 1) An adult patient must execute a living will directing that his or her life not be prolonged by life-sustaining procedures. 2) The living will must be signed in the presence of two witnesses. Each witness must certify in writing that the witness believes the declarant to be of sound mind and the declarant understands the effect of such directive, and that the witness: a) is not related to the declarant or to the declarant's spouse. b) does not know or have a reasonable expectation that the witness would be entitled to any portion of the estate of the declarant upon his or her death under any will of the declarant or codicil or under Florida's intestate succession statute. c) is not the attending physician or an employee of the attending physician, or an employee of a health facility in which the declarant is a patient, or an employee of a nursing home or any group care home in which the declarant resides, and d) does not have a claim against any portion of the declarant's estate at the time of the declaration.
>
> 3) Each witness shall sign his or her certification in the presence of a notary public. 4) The attending physician must certify that the patient will remain terminally ill, regardless of the utilization of life-sustaining procedures. This prognosis must be confirmed by a consulting physician, other than the attending physician, who has examined the patient.[169] 5) The living will may be revoked by the declarant in any manner by which he or she is able to communicate the intent to revoke, without regard to his or her mental or physical condition. Such revocation shall become effective only upon communication to the attending physician by the declarant or by an individual acting on behalf of the declarant.[170] 6) The withholding

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168. These guidelines are suggested in Petitioner's Brief on the Mertis (filed in the Florida Supreme Court) at ___, 432 So. 2d 611 (Fla. 4th D.C.A. 1983).

169. According to the *J.F.K. Memorial Hospital* court, certification requires that the patient has been diagnosed and certified in writing to be in terminal condition and that the prospects of regaining cognitive brain function are extremely remote. 432 So. 2d at 619.

> Life sustaining procedures are medical procedures which utilize mechanical means to sustain, restore, or supplant a vital function, which serves only or primarily to prolong the movement of death, and where, in the judgment of the attending and consulting physicians as reflected in the patient's medical records, death is imminent if such procedures are not utilized.

170. Allowing revocation at any time and in any manner prevents a patient from being unwillingly bound by his right to die assertion. Recognizing valid effectuation of this right only upon communication to the attending physician protects medical personnel from later charges of civil or criminal liability. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7189 (West Cum. Supp.

> or discontinuance of life-sustaining procedures in accordance with good faith compliance with these conditions shall not be considered the cause of death for any civil or criminal purposes and shall be a defense against any criminal or civil action asserted for compliance with those conditions.[171]

By implementing a procedure following the guidelines stated above, the Florida Supreme Court can assure Florida citizens that their privacy rights will be protected should they become incompetent.[172] While these procedural suggestions are not flawless, no single set of guidelines, moral, legal or medical, can be fashioned to resolve the infinite range of ethical considerations inherent in the physiology of dying. Rather, their purpose is to provide a minimum guarantee that Florida will protect an incompetent's constitutional right to make autonomous medical decisions, irrespective of legislative inaction.

Eight years have passed since Karen Quinlan slipped into a coma, yet an incompetent's constitutional right to die remains unsecured in Florida.[173] Consequently, the right of a terminally ill incompetent to avoid artificial prolongation of life through execution of a written directive is uncertain. While this complex issue is more suitably addressed in a legislative forum, the court cannot wait for statutory provisions before it acts to vindicate constitutionally protected rights. The court must protect an incompetent patient's right of self-determination by promulgating procedural guidelines which do not require judicial intervention.

No state interest exists to compel judicial encroachment on medical decisionmaking and individual autonomy. Ironically, this judicial overview procedure actually abridges the privacy rights of the very incompetents it purports to protect. Rather than safeguarding life, these procedures disregard an incompetent's directive and unduly prolong a possibly painful wait for death. The Florida Supreme Court should enforce the constitutional rights of incompetents and articulate a procedure that does not abrogate an individual's right to choose between life without consciousness or death with dignity.

1979-80). For an analysis of this and other provisions of the California Code, see generally, Note, *The California Natural Death Act: An Empirical Study of Physician's Practices*, 31 STAN. L. REV. 913 (1979).

171. *See, e.g.*, DEL. CODE ANN. tit. 16 § 2505 (1982). This Delaware section relieves medical personnel of liability and further allows a physician or nurse to assume that an individual executing a directive was of sound mind unless actual notice indicates otherwise. *Id.*

172. FLA. CONST. art. I, § 23.

173. *Perlmutter*, 379 So. 2d 359 (Fla. 1980). Since the supreme court limited its statement to the instant facts, the scope of the terminally ill's right to die is uncertain. *Id.*

IV. EPILOGUE

JUDICIAL AFFIRMATION AND LEGISLATIVE ENACTMENT OF A RIGHT TO DIE FOR BOTH COMPETENT AND INCOMPETENT ADULTS

Immediately prior to the publication of this issue, the Florida Supreme Court in *John F. Kennedy Memorial Hospital v. Bludworth*[1] unequivocally acknowledged the right of all terminally ill individuals to avoid extraordinary medical treatment when on the threshold of death.[2] Citing *Perlmutter*,[3] *Quinlan*,[4] and *Saikewicz*,[5] the court recognized that dying patients have the right to refuse extraordinary medical treatment, and concluded that a means must exist to allow assertion of this right. Utilization of mandatory court approval to effectuate this right, however, was deemed to be unnecessary for protection of state or patient interest.[6] Though not required in every case, the court noted that judicial review would be available in cases where doubt existed or where there was disagreement among the family, physician, and hospital.[7]

The supreme court next delineated specific requirements which doctors and family members must follow before life-sustaining treatment may be legally withdrawn from a terminally ill incompetent.[8] Under this procedure the treating physician must certify that the patient is in a permanent vegetative state with no reasonable prospect of regaining consciousness and that his existence is being sustained only through the use of extraordinary life-sustaining treatment.[9] Ad-

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1. 1984 Fla. L.W. 196 (Fla. May 25, 1984). Justice McDonald, concurring in result only, suggests that the court's elaboration on factual situations not before it was unnecessary. *Id.*

2. At the time the court issued this decision, the "Life Prolonging Procedure Act," discussed *infra*, had passed through the Florida House of Representatives without debate and was pending in the Florida Senate.

3. 362 So. 2d 160 (4th D.C.A. 1978), *aff'd*, 370 So. 2d 359 (Fla. 1980). *See supra* text accompanying notes 77-98 for a discussion of *Perlmutter*.

4. 70 N.J. 10, 355 A.2d 657, *cert. denied*, 429 U.S. 922 (1976). *See supra* notes 34-43 and accompanying text for a discussion of *Quinlan*.

5. 373 Mass. 728, 370 N.E.2d 427 (1977). *See supra* notes 44-55 and accompanying text for a discussion of *Saikewicz*.

6. 1984 Fla. L.W. at 197.

7. In support of this conclusion, the supreme court cited *In re* Guardianship of Barry, 445 So. 2d 365 (Fla. 2d D.C.A. 1984). In *Barry*, parents petitioned the court to remove the life support systems keeping their terminally ill comatose infant alive. *Id.* at 367. Affirming the trial court's holding, the Second District Court of Appeal concluded that the interests of the child as asserted through his parents outweighed any state interest in preservation of life. *Id.* at 370. The district court, in dicta, pointed out that judicial review is not required in every case before extraordinary treatment can be withheld from a terminally ill child. *Id.* at 371. Rather, a decision by parents supported by competent medical advice should sufficiently protect the child's interest without mandatory judicial intervention. *Id.* at 372.

8. 1984 Fla. L.W. at 198.

9. *Id.*

ditionally, two other physicians with specialties relevant to the patient's condition must concur with the treating physician's certification.[10]

Once these requirements are met, close family members or a court-appointed guardian may, through their substituted judgment, assert the terminally ill patient's right to die.[11] According to the court, if the patient had executed a living will while competent, then that declaration would provide persuasive evidence of the patient's intent and should be given great weight by persons utilizing substituted judgment on the incompetent's behalf.[12] The court held that if such procedures are followed in good faith, all involved parties are relieved of potential civil and criminal liability.[13]

Florida's highest judicial branch thus provided a viable procedure for implementing the constitutionally protected right to die. In so doing, the court appropriately laid to rest the previous inequitable differentiation between the rights of competent and incompetent terminally ill patients.[14] The medical community can now, without overriding fear of malpractice suits, withdraw medical treatment from patients desirous of such action.

Still the opinion leaves gaps. Extraordinary life-sustaining treatment may be withdrawn from a comatose patient, but no definition is given to aid the physician in determining exactly what constitutes such treatment. Thus, the medical profession remains without specifications and termination decisions may be inconsistently made. In addition, no priority is delineated among family members and guardians in the event their substituted judgments differ as to the incompetent's desires.[15]

Most importantly, the opinion fails to ensure that the incompetent's intent as expressed through a living will is actually carried out. The living will provides only "persuasive evidence" and no mandate forces the person acting on behalf of the incompetent to seek withdrawal of treatment. Thus, incompetents are once again, to a lesser degree, without the same assurance as competents that their expressed rights of privacy will be protected. Had the court spelled out specific guidelines as suggested earlier in this note,[16] an executed liv-

10. *Id.*

11. *Id. See supra* note 41 for an explanation of the substituted judgment doctrine.

12. 1984 Fla. L.W. at 198.

13. *Id.*

14. *Id. See supra* text accompanying notes 122-53.

15. The court does, however, specifically point out that the judiciary is always open to hear such matters, and disagreement among physicians or family members may recognize judicial intervention upon the filing of an appropriate petition. 1984 Fla. L.W. at 198.

16. *See supra* text accompanying notes 168-71.

ing will would provide more than persuasive evidence and rightfully place an individual's death decision under his sole determination.

Fortunately, most of these gaps were closed by the Florida legislature with the passage of the "Life-Prolonging Procedure Act of Florida."[17] Enacted only days after the supreme court's *J.F.K. Memorial Hospital* decision, the Act expressly recognizes the right of a competent terminally ill adult to have life-prolonging procedures withdrawn or withheld by executing an oral or written declaration or by designating another to make the treatment decision.[18] The statute specifically defines life-prolonging procedures[19] as well as terminal condition.[20] The Act also sets out the proper procedures for executing a legally binding directive and mandates that such directive become part of the patient's medical records.[21] A suggested declaration form is given, but need not be specifically followed, and oral, physical and written revocation procedures are specified.[22] If a terminally ill comatose individual has failed to execute a declaration, the statute provides that the physician and any of several specified individuals may confer and determine the patient's desire.[23] A list of individuals who may act on the incompetent's behalf is specifically delineated in order of priority.[24]

Reaching further than the judiciary, the legislature laudably makes mandatory the implementation of a properly executed living will. Any physician who refuses to comply with a patient's directive must make a reasonable effort to transfer the patient to another physician.[25] Additionally, the Act makes concealment, cancellation or falsification of another's declaration a third degree felony.[26] If, however,

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17. 1984 Fla. Laws c. 58 (effective May 30, 1984).
18. *Id.*
19. *Id.* § 3(3) defines "life-prolonging" procedure as:

> [A]ny medical procedure, treatment or intervention which: (a) utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function; and (b) when applied to a patient in a terminal condition would serve only to prolong the dying process.
>
> Life-prolonging procedure shall not include the provision of sustenance or the administration of medication or performance of any medical procedure deemed necessary to provide comfort, care or alleviate pain.

Id.

20. *Id.* § 3(6) defines "terminal condition" as "a condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty, there can be no recovery and death is imminent." *Id.*
21. *See id.* § 4.
22. *See id.* §§ 5, 6.
23. *Id.* § 7.
24. *See id.* § 7(a)-(f).
25. *Id.* § 8.
26. *Id.* § 10. In order to be punished under this section and as provided in FLA. STAT. §§

all persons involved in terminating the treatment act in good faith, they shall be relieved of any criminal or civil liability.[27] Moreover, an apparently valid declaration is presumed to be voluntary, thereby alleviating the need for probate-like proceedings.[28]

As with any new statute, the Act contains certain ambiguities which must be resolved through time and interpretation. On the one hand, the Act appears to go even further than the supreme court's opinion in protecting the rights of both competents and incompetents by making the implementation of a living will mandatory. In addition, the expressed intent of a terminally ill patient who later becomes incompetent cannot be overruled by another's substituted judgment. On the other hand, three classes of patients who received implicit protection under *J.F.K. Memorial Hospital*, those pregnant, underage, and non-imminently terminal, are expressly excluded from the Florida Act's purview.

The Act states that the termination decision of an otherwise "qualified patient"[29] diagnosed as pregnant shall have no effect during the course of pregnancy. Such a provision is inconsistent with the Supreme Court's holding in *Roe*, since during the first trimester of pregnancy, a woman's privacy interest outweighs all state interests in the life of a fetus.[30] Thus a terminally ill female in the early stages of pregnancy should be allowed the same right to avoid prolongation of death as nonpregnant individuals. Furthermore, this provision in effect revives the differential rights of competents and incompetents. If a terminally ill pregnant patient in her first trimester is conscious, she may terminate her pregnancy and thereafter effectuate her living will. Regardless of her desire, however, a similarly situated pregnant patient who is unconscious is unable to take such action to carry out her right to a natural death.

Likewise, the Act provides that only adults may execute living wills,[31] yet the statute's substituted judgment procedures are inapplicable to minors.[32] Though preventing automatic implementation of a minor's living will seems appropriate for the same policy reasons that

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775.082, .083 or .084, the person tampering with the declaration must have caused actual contravention of the patient's intent either by causing him a prolonged life when he preferred death or death when he preferred life-prolongation.

27. 1984 Fla. Laws c. 58, § 9(1), (2).

28. *Id.*

29. The Act defines a qualified patient as one who has made a declaration in accordance with this Act and been diagnosed and certified in writing by the attending physician, and by one other physician who has examined the patient, to be afflicted with a terminal condition. 1984 Fla. Laws c. 58, § 3(5).

30. *See supra* notes 25-33 and accompanying text.

31. 1984 Fla. Laws c. 58, § 4(1).

32. *Id.* § 7(1).

prevent numerous other rights from vesting in non-adults, the statute's designation of substituted judgment procedures solely for adult patients is problematic. If applied to children, the procedures would provide adequate safeguards by requiring a witnessed consultation and decision by the parent in conjunction with the attending physician.[33]

Less explicitly, the statute's definition of "terminal condition" includes the requirement that death is imminent, but fails to indicate whether this qualification means imminent death with or without the use of life-support systems. If a narrow interpretation of this requirement is applied, a person in a permanent vegatative state whose life can be prolonged indefinitely through artificial treatment may be exluded from those patients who possess a statutory right to die.

Resolution of this ambiguity between judicial and legislative classification of those possessing a right to die is made even more difficult by the following section[34] which states: "provisions of the Act are cumulative with existing law . . . and shall not impair any rights or responsibilities. . ." which doctors, patients, whether minor or incompetent, or family members may have in regard to withdrawal of life-prolonging procedures under the common law. Thus, under this section, pregnant females, minors, and persons in a permanent vegetative state[35] might still assert their right, as elucidated by the judiciary, to have life-prolonging treatment withheld without prior court approval.[36]

A fuller analysis of the interplay between the statute and the supreme court's holding is difficult as both actions are so recent. No doubt they will spawn litigation, particularly since the supreme court's opinion appears to recognize constitutional rights which the legislature's action immediately dissolves. While the supreme court's broad coverage may be preferable, the statute's explicit procedures are indispensable. Though the parameters are not yet clear, both the Florida Supreme Court and the Florida legislature should be applauded for independently acting to assure protection of their citizens' constitutional right to avoid life-prolonging pain.

KIMARIE R. STRATOS

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33. *See id.* § 7(1)-(3). Interestingly, this section requires only the attending physician, in coordination with the patient's representative to certify in writing that the withdrawal decision was made. Section 7(2) provides that this consultation be made in the presence of two witnesses, but no other physician is required to double check the attending physician's diagnosis, as is the case when effectuating a written declaration according to § 3(5) and (8).

34. *Id.* § 13.

35. *See supra* text accompanying note 33.

36. Since the Act does not take effect until Oct. 1, 1984, these classes must at least possess full rights under the court's opinion until that date.