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CRIMINAL LAW: WHO WILL DECIDE WHEN A PATIENT MAY DIE?

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

Suffering from a terminal illness, Abe Perlmutter, a competent seventy-three year old hospital patient, attempted to remove the respirator sustaining his life.[1] Although his family supported his decision, the Florida Medical Center prevented Perlmutter from disconnecting the life-support system.[2] The patient then petitioned the circuit court for an order restraining the hospital from continuing his life-sustaining treatment.[3] The circuit judge issued the restraining order in recognition of Perlmutter's constitutional right of privacy.[4] Affirming the circuit court order, the Fourth District Court of Appeal ruled that a competent patient[5] has a constitutional right of privacy to refuse life-prolonging treatment after the prognosis of an agonizing terminal illness.[6] On certiorari,[7] the Supreme Court of Florida adopted the opinion of the district

1. Satz v. Perlmutter, 362 So. 2d 160, 161 (Fla. 4th D.C.A. 1978). Mr. Perlmutter was afflicted with amyotrophic lateral sclerosis, commonly known as "Lou Gehrig's disease." The normal life expectancy for a patient with this disease is two years. Mr. Perlmutter's doctors did not expect him to live more than a few hours if the respirator was removed. During the sixteen months of the progression of this case through the courts he remained alive but unable to move, and able to communicate only on a limited basis. *Id.*

2. *Id.* Mr. Perlmutter had attempted to remove the respirator, but an alarm notified the hospital staff who quickly reconnected the apparatus. He had repeatedly requested that his family disconnect the respirator. *Id.*

3. Perlmutter v. Florida Medical Center, 47 Fla. Supp. 190 (Broward County Cir. Ct. 1978).

4. The trial court decision read in part: "[I]t is ordered and adjudged that Abe Perlmutter, in exercise of his right of privacy, may remain in defendant hospital or leave said hospital, free of the mechanical respirator now attached to his body and all defendants and their staffs are restrained from interfering with plaintiff's decision." *Id.* at 194.

5. The court stressed that Mr. Perlmutter "remains in command of his mental faculties and legally competent." 362 So. 2d at 161. The standard by which the court determined that Mr. Perlmutter was competent was not expressly established, though the court's decision clearly depended on a finding of competency. *Id.* at 162.

In cases involving the determination of the competency of a testator, the Supreme Court of Florida has set forth definite standards of competency. "A court should not set aside a will, deed, or other agreement for mere mental weakness if it does not amount to inability to comprehend the effect and nature of the transaction and is unaccompanied by evidence of imposition of undue influence." Gardiner v. Goertner, 110 Fla. 377, 384, 149 So. 186, 189 (1933). Apparently applying a similar standard, the court found that Mr. Perlmutter had sufficient mental ability to comprehend the inevitable result of his choice, and that the decision was the result of his own volition. 362 So. 2d at 161.

6. *Id.* at 164. "It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However . . . [s]uch a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self-determine." *Id.*

7. Despite a concurring opinion urging that the case be certified to the supreme court, the District Court of Appeal refused because it desired to put the *Perlmutter* decision into effect immediaetly. 362 So. 2d at 164. The state filed a petition for writ of certiorari. The supreme court took jurisdiction pursuant to FLA. CONST. art. V, §3(b)(3), relying on the fact that the lower court decision directly affected the rights and duties of state attorneys, who form a class of constitutional officers. 379 So. 2d 359 (Fla. 1980).

court,[8] limited its decision to this particular fact situation,[9] and HELD, the state's interest in the preservation of life and maintaining the ethical integrity of the medical profession did not outweigh the right of the individual to refuse medical treatment.[10]

The right of an individual to refuse medical care has traditionally been protected by the common law doctrine of informed consent[11] which prohibits doctors from treating patients without authorization. Even in its earliest acknowledgment of the right of the individual to control his physical integrity, however, the United States Supreme Court recognized that the state may place limits on this personal right.[12] As patients have claimed a right of privacy,

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8. 379 So. 2d 359. Although the decision of the supreme court concentrated primarily on jurisdictional issues, the court expressly adopted the entire analysis of the District Court of Appeal, bestowing the authority of the supreme court on that opinion. Writing for the court, Justice Sundberg stated: Because of the clarity of reasoning and articulation of the applicable principles of law contained therein, little could be added by our reformulation of the matters set forth in the opinion below. Accordingly, we adopt the opinion of the district court as our own with the caveat that the reach of this decision does not extend beyond the particular facts presented in the case before us. *Id.* at 360.

9. *Id.* Even though the district court opinion expressly limited its decision to the specific facts of the instant case, the supreme court reiterated this limitation. See note 8 *supra*.

10. 379 So. 2d 359 (Fla. 1980).

11. The common law in every state prohibits doctors from administering medical treatment without informed consent. Cantor, Quinlan, *Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 248 (1976). *See, e.g.*, Scholendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914) (surgeon who performs an operation without his patient's consent commits assault); Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962) (doctors may not administer blood transfusions to non-consenting adult).

The doctrine of informed consent establishes a dual responsibility for physicians: 1) a duty to disclose to the patient the nature and ramifications of available treatments, and 2) a duty to obtain the patient's consent to any treatment prior to its administration. Recent judicial decisions have established the responsibility of a physician to adequately inform his patient of treatment alternatives as an integral protection of the informed consent doctrine. *See* Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957); Natanson v. Kline, 186 Kan. 393, 407, 409, 350 P.2d 1093, 1103-04 (1960). The duty to obtain a patient's consent to treatment has been protected in the common law since Slater v. Baker & Stapleton, 95 Eng. Rep. 860 (K.B. 1767). *See generally* Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WISC. L. REV. 413 (1979); Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977); Roth & Wild, *When the Patient Refuses Treatment: Some Observations and Proposals for Handling the Difficult Case*, 23 ST. LOUIS UNIV. L. J. 429 (1979).

The doctor's duty to obtain the consent of the patient before commencing treatment establishes the right of the patient to determine whether or not he will submit to any of the possible treatments. This portion of the informed consent doctrine is tantamount to a right of privacy to refuse medical care.

The court apparently assumed that the physician's duty to inform the patient of treatment alternatives had been met. The court noted that Mr. Perlmutter was fully aware of the ramifications of his decision to disconnect the respirator. 379 So. 2d at 360 (approving decision at the Fourth District Court of Appeal). Consequently, the only facet of the informed consent doctrine which remained to be considered was the patient's right to refuse treatment. The court chose to treat this issue, not under the doctrine of informed consent, but as a constitutional right of privacy. *Id.* See note 8 *supra*.

12. Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891). "No right is held more sacred,

courts have consistently balanced this interest against the state's interest in protecting the health, safety, and morals of the community.[13]

In the absence of a decision from the United States Supreme Court defining the patient's right to refuse treatment, lower courts have struggled to weigh the competing interests of the state and the individual. The United States Court of Appeals for the District of Columbia, in *In re President & Directors of Georgetown College, Inc.*,[14] decided that a number of governmental interests overcame both a patient's right of privacy and her right to exercise her religious beliefs.[15] In *Georgetown*, the hospital sought a court order authorizing blood transfusions necessary to save the life of a young mother.[16] After the district court denied the request,[17] the circuit court enumerated several factors which favored forcing the patient to receive medical treatment. Under the doctrine of *parens patriae*, the government had an interest in preserving the life of the mother for the sake of her infant child.[18] Similarly, the government should protect the patient, whose weakened physical condition diminished her mental capacity to decide on necessary treatment.[19] A third factor was the

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 of interferences of others, unless by clear and unquestionable authority of law." *Id.*

13. *See, e.g.*, Buck v. Bell, 274 U.S. 200 (1927) (state permitted to sterilize incompetents); Jacobson v. Massachusetts, 197 U.S. 11 (1905) (state could require small-pox vaccination); Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769 (courts may order compulsory medical treatment of children), *cert. denied*, 344 U.S. 824 (1952).

14. 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

15. *Id.* Patients have often demanded a right to refuse medical treatment based on the first amendment guarantee of free exercise of religion. U.S. CONST. amend. I. Many of these cases have involved the Jehovah's Witnesses' refusal of blood transfusions as a mandate of their religious faith. *See, e.g., In re* Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (court refused to authorize blood transfusion for nonconsenting Jehovah's Witness). These cases have precedential value for the instant case because the governmental interests which are balanced against the right to religious freedom are applicable when weighing a patient's constitutional right of privacy.

16. 331 F.2d at 1001-02. The patient, a twenty-five year old mother of a seven-month-old child, had lost two-thirds of her blood supply from a ruptured ulcer. Because of her religious beliefs as a Jehovah's Witness, the patient and her husband refused to consent to blood transfusions which doctors believed were essential to prevent her death. *Id.* at 1006.

17. *Id.* at 1002 n.4.

18. *Id.* at 1008. Courts have invoked the common law *parens patriae* doctrine to protect the governmental interest in preserving the health of minors and incompetents. Thus, if the death of a patient would threaten the well-being of children, the *parens patriae* doctrine authorizes the court to prevent the patient's death for the sake of these third parties. *See* United States v. George, 239 F. Supp. 752 (D. Conn. 1965) (court ordered necessary blood transfusions for father of four minors); Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (court ordered blood transfusion for pregnant woman), *cert. denied*, 377 U.S. 985 (1964).

The *parens patriae* interest also empowers the state to protect the health of mentally incompetent citizens. In situations in which a patient has been adjudged incompetent, this state interest has predominated over the patient's right to reject treatment, permitting courts to order medical care. See notes 74-75 and accompanying text, *infra*. In these different contexts, the *parens patriae* doctrine authorizes court action to protect the health of both third parties and incompetent patients.

19. 331 F.2d at 1008. Although the patient was able to communicate that she would not authorize the transfusion, the circuit court judge stated that she was obviously not in a

government's interest in assisting the medical profession to fulfill its responsibility to a patient who had committed herself to the care of the hospital.[20] Finally, the fact that the patient would die if the court did not sanction treatment against her will persuaded the court to decide that the state's interest was dominant.[21]

The right to privacy has subordinated governmental interests in other areas of the law. In *Roe v. Wade*[22] the United States Supreme Court balanced compelling governmental interests against a woman's right to terminate her pregnancy. Acknowledging constitutional protection for a fundamental right of privacy,[23] *Roe* established that state criminal abortion laws may not abridge a woman's right to obtain an abortion during the first trimester of pregnancy.[24] The Court expanded the right of privacy beyond the traditional areas of marriage,[25] contraception,[26] and education,[27] by upholding the right of the

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mental condition of making the decision. The court decided it had a duty to assume the responsibility of guardianship for her. *Id. Accord,* Nathan & Miriam Barnert Memorial Hosp. Ass'n v. Young, 63 N.J. 578, 311 A.2d 1 (1972) (guardian appointed to consent to amputation); *In re* Schiller, 148 N.J. Super. 168, 372 A.2d 360 (Ch. 1977) (court appointed guardian to consent to amputation when elderly patient could not comprehend that surgery was necessary to save her life). *But see* Lane v. Candura, 376 N.E.2d 1232 (Mass. 1978) (refusal of a necessary operation is not presumptive evidence of incompetence); *In re* Nemser, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966) (court refused to sanction amputation for elderly woman who could not comprehend that the operation was necessary).

20. 331 F.2d at 1009. The circuit court judge held that the patient did not have the right to limit the doctor's ability to effectively treat a patient who had committed herself to his care. *Id.*

21. *Id.* at 1009-10. The inevitability of death without government imposed treatment has not always triumphed over the patient's right to refuse medical care. *Compare* John F. Kennedy Mem. Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971) (preserving the life of the patient was a compelling state interest sufficient to defeat the patient's right to refuse blood transfusions) *and* Powell v. Columbian Presbyterian Medical Center, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965) (court decided it could not let the patient die) *with In re* Osborne, 294 A.2d 372 (D.C. 1972) (patient's right to refuse blood transfusions could be exercised even if death was the inevitable result) *and In re* Melideo, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976) (court refused to authorize necessary transfusion when it was against competent patient's will).

22. 410 U.S. 113 (1973).

23. Although the Constitution does not expressly mention a right of privacy, the Supreme Court has recognized that there is constitutional protection for certain areas or zones of privacy. *Id.* at 152. The Court has attributed this guarantee to the first amendment, Stanley v. Georgia, 394 U.S. 557, 564 (1969); the penumbras of the Bill of Rights, Griswold v. Connecticut, 381 U.S. 479, 484-85 (1965); or to the liberty protected by the fourteenth amendment, Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

24. The *Roe* Court thus applied the right of privacy to a new context, criminal abortion laws. The court held that a woman has a qualified, fundamental right to choose whether to terminate her pregnancy. This right can be limited only by compelling state interests. 410 U.S. at 154. The court found no state interests sufficient to outweigh the right of privacy during the first three months of pregnancy. *Id.*

25. *See, e.g.,* Loving v. Virginia, 388 U.S. 1 (1967) (right to marry without racial restrictions).

26. *See, e.g.,* Griswold v. Connecticut, 381 U.S. 479 (1965) (right of married couples to obtain contraceptives).

27. *See, e.g.,* Pierce v. Society of Sisters, 268 U.S. 510 (1925) (right to choose education for children).

patient to make medical decisions without interference by the state.[28]

Armed with this expanded view of the privacy right, legislatures in several states have sought to establish standards for the right to refuse necessary medical treatment.[29] The California legislature, for example, passed the Natural Death Act in 1976.[30] This statute authorized competent adults to sign a standardized directive[31] which instructs their physicians to withhold life-sustaining treatment if they are diagnosed as terminally ill.[32] Moreover, the statute abolished criminal and civil liability for doctors who withhold treatment in accordance with the patient's decision.[33]

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28. 410 U.S. at 153. "The right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Id.*

Although the right of privacy has been primarily applied to areas involving marriage and the family, *Roe* indicates that other "zones" of privacy exist. In upholding the right of a woman to decide to have an abortion, the Supreme Court did not determine the boundaries of the privacy right. Thus, it has been argued that the right of a patient to refuse medical treatment is another area to which the constitutional right of privacy should apply. For a discussion of the evolution of the constitutional right of privacy and its present definition see Comment, Roe v. Wade *and* In re Quinlan: *Individual Decision and the Scope of Privacy's Constitutional Guarantee,* 12 U.S. F. L. REV. 111 (1977). *See generally* J. SHATTUCK, RIGHTS OF PRIVACY 122-26 (1977).

29. Natural death legislation has been considered in twenty-seven states. Note, *The California Natural Death Act: An Empirical Study of Physicians' Practices,* 31 STAN. L. REV. 913, 917 n.20 (1979) [hereinafter cited as *An Empirical Study*]. In Florida alone, a dozen proposed statutes have been considered, though none has been passed. 362 So. 2d at 164.

Seven states, in addition to California, have enacted natural death laws: ARK. STAT. ANN. §§82-3801 to -3804 (Supp. 1977); IDAHO CODE §§39-4501 to -4508 (Supp. 1978); NEV. REV. STAT. §449.540-.690 (1977); N.M. STAT. ANN. §§24-7-1 to -11 (1978); N.C. GEN. STAT. §§90-320 to -322 (Supp. 1977); OR. REV. STAT. §§97.050-.090 (1977); TEX. HEALTH AND SAFETY CODE ANN. tit. 4590h, §§1-11 (Vernon Supp. 1978).

30. CAL. HEALTH & SAFETY CODE §§7185-95 (West Cum. Supp. 1979-80). California was the first state to pass a natural death act. *See An Empirical Study, supra* note 29, at 917. Three states which have enacted similar statutes have used the California act as a model. *Id.* at 917 n.20.

31. The directive reads in part:

"1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

. . . .

"6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive."

CAL. HEALTH & SAFETY CODE §7188 (West Cum. Supp. 1979-80).

32. The phrase "terminal condition" does not have a definite meaning. Although a majority of doctors accept the definition of "an illness that progresses to death regardless of what is done," more than 40% of doctors surveyed in California indicated that the meaning of "terminal condition" varies with each patient and illness. *An Empirical Study, supra* note 29, at 932.

33. CAL. HEALTH & SAFETY CODE §7190 (West Cum. Supp. 1979-80). In many cases, the doctor's decision regarding treatment still supersedes the patient's right. If the patient fails to re-execute the directive after the diagnosis of terminal illness, the doctor considers the patient's choice to die as only one factor in the doctor's decision regarding treatment. *Id.* §7191(c).

In states without an applicable statute, the courts have arrived at varying standards for compelling medical treatment, reflecting differing conceptions of the right of privacy.[34] The New Jersey supreme court decided in *In re Quinlan*[35] that no compelling state interest could force Karen Quinlan to have her life prolonged by a mechanical respirator.[36] The court ruled that the right of privacy included a patient's decision to refuse life-sustaining treatment under those facts.[37] Establishing the limits of the patient's right, the court noted that the state's interest weakens and the privacy right is enhanced when an increasing risk of bodily invasion exists with a minimal likelihood of recovery.[38] If there is no reasonable hope of the patient returning to cognitive, sapient life,[39] the patient's decision to refuse treatment must be honored.[40]

The Massachusetts Supreme Judicial Court has not limited the right of privacy to patients lacking cognitive life. In *Superintendent of Belchertown v. Saikewicz*,[41] a state mental institution sought authorization to give chemotherapy treatments to a profoundly mentally retarded victim of leukemia.[42]

For a discussion of the extent to which the Natural Death Act facilitates the patient's exercise of the right of privacy, see *An Empirical Study, supra* note 29; Comment, *The Right to Die a Natural Death: A Discussion of* In Re Quinlan *and the California Natural Death Act*, 46 U. CIN. L. REV. 192 (1977) [hereinafter cited as *The Right to Die*].

34. Judicial decisions concerning the right to refuse medical care have not been consistently based on a right of privacy. The instant case, as well as cases from other jurisdictions, however, equated the patient's right to refuse treatment with the right of privacy. 362 So. 2d at 164.

35. 70 N.J. 10, 355 A.2d 657, *cert. denied*, 429 U.S. 922 (1976).

36. *Id.* at 39, 355 A.2d at 663. Karen Ann Quinlan, twenty-two years old, was in a coma with only the vegetative functions of her brain operating. The trial court refused to allow removal of the respirator, noting that withholding treatment from a patient who did not meet the criteria of "brain death" would violate current medical standards. *In re* Quinlan, 137 N.J. Super. 227, 348 A.2d 801 (Ch. 1975).

37. 70 N.J. at 40, 355 A.2d at 663. *See* Coburn, In re Quinlan: *A Practical Overview*, 31 ARK. L. REV. 59, 69 (1977). For a discussion of the patient's right to decline necessary medical treatment and the possibilities of criminal liability, see Collester, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304 (1976).

38. 70 N.J. at 41, 355 A.2d at 664. *Cf. In re* Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (1978) (amputation of both legs was "extensive bodily invasion" making the right of privacy paramount to the state's interest). This standard leaves a great deal of discretion to the courts. *See generally* Cantor, *supra* note 11; Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of* In re Quinlan, 30 RUTGERS L. REV. 267 (1976).

39. The testimony of expert witnesses convinced the court that there was no realistic possibility of Karen resuming cognitive life. 70 N.J. at 26, 355 A.2d at 655. A cognitive state requires awareness of the patient's surroundings and the ability to make some mental judgments. Similarly, Dr. Fred Plum testified that the human brain functions in two capacities: vegetative and sapient. The vegetative functions of Karen's brain were still working, controlling and regulating body temperature, blood pressure, sleeping and waking. Because her brain was operating at this reflex level, it was not biologically dead. However, Karen's brain did not function at the sapient level which is characteristic of the human brain. According to Dr. Plum, sapient life includes the capacity to talk, see, feel, think, and sing. *Id.* at 24, 355 A.2d at 654-55.

40. *Id.* at 55, 355 A.2d at 672.

41. 370 N.E.2d 417 (Mass. 1977).

42. Mr. Saikewicz was sixty-seven years old, with a mental age of two years and eight months. He was diagnosed as having acute myeloblastic monocytic leukemia, an incurable

The court recognized a substantive right of both competent and incompetent patients to refuse life-prolonging treatment.[43] This right was not viewed as absolute, however, and might be limited by the interests of the state.[44] Four government interests were noted as relevant to the patient's right to refuse treatment. First, the court identified state interests in preserving life[45] and in preventing suicide.[46] In addition, the court recognized state interests in protecting dependent third parties who would suffer from the patient's death[47] and in maintaining the ethical integrity of the medical profession.[48]

The instant case relied heavily on the standards announced in *Saikewicz*, as the Supreme Court of Florida considered for the first time a patient's right to refuse life-sustaining medical care.[49] In a unanimous decision,[50] the Florida supreme court adopted the appellate court's analysis in its entirety,[51] affirming the preeminence of the patient's right of privacy over legitimate state interests. The court interpreted the constitutional right of privacy as protecting the right of a patient to reject extraordinary medical treatment[52] when the evidence

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and terminal disease. *Id.* at 420. Belchertown State School, a state mental institution. petitioned the Probate Court of Hampshire County for appointment of a guardian to make decisions concerning his treatment. The guardian *ad litem* decided that chemotherapy, which would cause pain and discomfort, should not be administered to prolong the patient's life. *Id.* at 419.

43. *Id.* at 424, 427. *See generally* Comment, *Constitutional Law — Right of Privacy — Qualified Right to Refuse Medical Treatment May Be Asserted for Incompetent Under Doctrine of Substituted Judgment,* 27 EMORY L.J. 425 (1978).

44. 370 N.E.2d at 424.

45. *Id.* at 425-27. The court decided that the state's interest in the preservation of life was lessened by a diagnosis of a terminal disease. Then the court rejected the idea that the state might have a greater interest in protecting the life of a competent patient than the life of an incompetent patient. Finally, the court equated this state interest with the protection of the sanctity of life, which was ill-served by any decision that did not recognize an individual right of self-determination. *Id.*

46. *Id.* at 426. The court reasoned that the state's interest in preventing suicide was not applicable in this case because Mr. Saikewicz had no specific intent to die and because his affliction was not self-induced. *Id.* at 426 n.11.

47. *Id.* at 427. Because Mr. Saikewicz had no dependents, the court held that the state's interest in protecting third parties was not a factor in this decision. *Id.* at 426.

48. *Id.* The court decided that rejecting chemotherapy was consistent with prevailing medical ethics. As evidence of the current ethical standards of the medical profession, the court quoted Lewis, *Machine Medicine and Its Relation to the Fatally Ill,* 206 J.A.M.A. 387 (1968), "[W]e should not use extraordinary means of prolonging life or its semblance when . . . there is no hope for the recovery of the patient. Recovery should not be defined simply as the ability to remain alive; it should mean life without intolerable suffering." 370 N.E.2d at 424.

49. 379 So. 2d at 360 (Fla. 1980) (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162). See note 8 *supra*.

50. Justice Adkins concurred in the result only. 379 So. 2d at 361.

51. *Id.* See note 8 *supra*.

52. The *Quinlan* court recognized a distinction between "ordinary" and "extraordinary" medical treatment, noting that the respirator was an extraordinary measure for dying, as opposed to curable, patients. 70 N.J. at 48, 355 A.2d at 668. However, the definition of "extraordinary treatment" remains unclear. *See* Hirsch & Donovan, *supra* note 38, at 289-91. A frequently cited definition of "extraordinary means" is "all medicines, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other in-

overwhelmingly indicates unbearable pain and imminent death.[53]

Following the *Saikewicz* rationale, the court first balanced Perlmutter's right of privacy against the state's interest in preserving life.[54] Emphasizing the diagnosis of a terminal illness and the patient's excruciating suffering, the court held that the state had no compelling interest in forcing treatment.[55] The court then concluded that the patient's decision to reject life-prolonging treatment did not threaten the state's interest in preventing suicide.[56] Accepting Perlmutter's testimony that he wanted to live, and noting that he had not caused the affliction which would lead to his death, the court refused to equate the passive act of declining treatment with homicide.[57]

The instant court found that the two remaining state interests contemplated in *Saikewicz* were also subordinate to Perlmutter's right of privacy. The court indicated that if the patient's death were tantamount to abandoning a minor child for whose care the patient was responsible, the state would have a strong *parens patriae* interest in compelling life-sustaining treatment.[58] However, since all the members of Perlmutter's immediate family were legally competent, the court found no third party potentially burdening the state's resources for proper care.[59] Finally, the court considered the state's interest in protecting the ethical integrity of the medical profession and noted that prevailing medical ethics do not require the prolongation of life in all circumstances.[60]

convenience, or if used, would not offer a reasonable hope of benefit." Kelly, *The Duty to Preserve Life,* 12 THEOL. STUDIES 550 (1951). It has also been suggested that extraordinary treatment is any measure which can have no further "curative effect." Ramsey, *Prolonged Dying: Not Medically Indicated,* HASTINGS CENTER REP., Feb. 1976, at 14.

53. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162, 164). See note 8 *supra.* The standard of "imminent death" is essential to an interpretation of the California Natural Death Act. But the definition of "imminent death" is uncertain. Though some doctors considered the standard met if death would certainly occur within a week, others defined "imminent" as death within twenty-four hours. *See An Empirical Study, supra* note 29, at 933.

54. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162). See note 8 *supra.*

55. *Id.* The supreme court adopted the analysis in *Saikewicz*: "[T]here is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the state interest where, as here, the issue is not whether, but when, for how long and at what cost to the individual his life may be briefly extended." 370 N.E.2d at 425-26. Clearly the cost to Perlmutter was great; the court viewed the respirator as "inflicting never ending physical torture. . . ." 362 So. 2d at 164. See note 8 *supra.*

56. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162-63). The Fourth District Court of Appeal held that Perlmutter's desire to live and the fact that he had not caused his physical condition "precludes his further refusal of treatment being classed as attempted suicide." *Id.* See note 8 *supra.*

57. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 163). Although Mr. Perlmutter sought permission to effect an affirmative act of disconnecting the respirator, the court found this analogous to a cancer patient who decides to refuse surgery—clearly a passive act. *Id.*

58. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162). The Fourth District Court of Appeal cited the *Georgetown* decision as an example of a factual situation in which the state's *parens patriae* interest surmounted the patient's right to refuse treatment. *Id.*

59. *Id.*

60. *Id.* at 360 (approving the decision of the Fourth District Court of Appeal, 360 So. 2d

The right to refuse life-sustaining treatment, the court maintained, is consistent with current medical ethics which emphasize the need to comfort, rather than treat, dying patients.[61] Thus, no relevant state interest was sufficient to defeat Perlmutter's right of privacy.[62]

While establishing standards for balancing the patient's right of privacy against the state's interests, the Supreme Court of Florida specifically limited its decision to the facts of the instant case.[63] The court predicted, however, that a comprehensive solution to the right-to-die issue would have to encompass a multitude of fact situations.[64] Therefore, the court insisted that the patient's right to refuse treatment was a question best solved by the legislature.[65] The factors on which the court based its decision should provide guidelines for the statutory solution sought by the court.

The court's language suggested that a legislative definition of the patient's right to refuse treatment should reflect the state's interest in the preservation of life.[66] By concluding that imminent death and prolonged suffering weaken this state interest, the court established a limit on the state's ability to compel the preservation of life.[67] Although the court indicated that the diagnosis of a terminal illness lessens this state interest, the effect of other factors such as an absence of cognitive life remained unclear.[68] The court did not decide whether

at 163-64). Citing *Saikewicz*, the court claimed that allowing Mr. Perlmutter to die would not violate current medical ethical standards. Accordingly, the court discounted the weight of the state's interest in maintaining the ethical integrity of the medical practice and of aiding all members of the medical profession in fulfilling their responsibilities to Mr. Perlmutter. *Id.*

61. "Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in *Quinlan*, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment." *Id.* See note 79 *infra.*

62. "It is our conclusion, therefore, under the facts before us, that when these several public policy interests are weighed against the rights of Mr. Perlmutter, the latter must and should prevail." 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 164).

63. 379 So. 2d at 360. See note 9 *supra.*

64. *Id.* at 361. The court indicated that the State had urged the judiciary to abstain from deciding this case because of the dangerous precedent it would set for widely varying circumstances and the intricate issues it involved. Because the constitutional rights of Mr. Perlmutter were in jeopardy, however, the court refused to postpone the resolution of this case. The court quoted Dade County Classroom Teachers Ass'n. v. Legislature, 269 So. 2d 684 (Fla. 1972): "[I]t is primarily the duty of the legislative body to provide the ways and means of enforcing . . . [constitutional] rights; however, in the absence of appropriate legislative action, it is the responsibility of the courts to do so." *Id.* at 686.

65. 379 So. 2d at 360. "It is the type issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated." *Id.*

66. *Id.* The court recognized that the patient's right to refuse treatment involved the interests of many parties, all of which should be considered in a legislative decision. The four state interests enunciated by the court were clearly viewed as most urgentlv in need of legal protection. *See* 362 So. 2d at 162.

67. 379 So. 2d at 360.

68. The Florida supreme court specifically confined its analysis to the case of a competent

such other evidence would also define the scope of the state's interest in forcing life-prolonging treatment.

This interest in preserving life parallels the state's concern with preventing suicide. Because disconnecting the respirator would inevitably result in death from natural causes, the instant court refused to equate Perlmutter's impending death with suicide.[69] In an isolated departure from the facts of this case, the court, in dicta, proclaimed that there is no legal duty for the competent, terminally ill to undergo surgery which would only temporarily prolong life.[70] Similarly, the court held the affirmative act of disconnecting the respirator prolonging Perlmutter's life was equivalent to a passive act of declining surgery.[71] Stressing Perlmutter's testimony that he desired to live, the court indicated that only intentional death invokes the state's interest in preventing suicide.[72] Although concluding that Perlmutter's death did not constitute suicide, the court neither defined suicide nor established whether the state has an absolute

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patient, but mental disability has affected the state's interest in preserving life in other courts. The *Quinlan* court held that the improbability of the patient returning to cognitive, sapient life diminished the state's interest in preserving life. 70 N.J. at 41, 355 A.2d at 664. Another factor, the degree of bodily invasion necessary to sustain life, further curtailed this state interest in the *Quinlan* decision. *Id.* The court's consideration of these factors indicated that the state's interest in preserving life may involve a judgment of the quality of the patient's prospective life. The dangers of courts determining a patient's right by a "quality of life" value judgment has been a criticism of the *Quinlan* decision. *See, e.g.*, Cantor, *supra* note 11, at 265.

69. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 163). The *Saikewicz* court used similar reasoning. 370 N.E.2d at 426 n.11.

70. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 163).

71. *See id.* Referring to the hypothetical situation in which a terminally ill patient rejects surgery, the court reasoned that in both that situation and Mr. Perlmutter's case, the patient was "choosing not to avail himself of one of the expensive marvels of modern medical science." *Id.*

In another section of the opinion, the supreme court referred to the various situations in which a patient might choose to refuse treatment as being the result of advances in medical science. 379 So. 2d at 361. For a discussion of the rapidly evolving medical practices which increase life-sustaining ability, see Belligie, *Medical Technology As It Exists Today*, 27 BAYLOR L. REV. 31 (1975). The moral decisions which determine when a patient may die, however, have confronted all generations prior to present technology. "Whenever the duty to relieve suffering has clashed with the value of life itself, the essential issues have been the same as those we face today." T. ODEN, SHOULD TREATMENT BE TERMINATED? xvi (1976).

72. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162-63). The court insinuated that the state's interest in preventing suicide would prevail over the patient's right to reject treatment if the patient's primary intention was to die. Thus, Mr. Perlmutter's desire to live was a factor weighing in favor of upholding his right of privacy. This seems contrary to *Georgetown*, where the patient's expressed desire to live influenced the court in its decision to force medical treatment. The court distinguished *Georgetown* and similar cases from Mr. Perlmutter's situation, noting that the patients in these prior decisions were either incompetent or equivocal in their expressed decisions. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 163). *Cf. In re* Osborne, 294 A.2d 372 (D.C. App. 1972) (court refused to order blood transfusions for a Jehovah's Witness against his will while noting that he wanted to live). In *Saikewicz*, the court decided that the absence of an intent to die made the state's interest in preventing suicide inapplicable. See note 46 *supra*.

duty to prevent it. A codification of the patient's right to refuse necessary medical treatment may require that the legislature define suicide and establish whether the state may force treatment whenever death would be tantamount to suicide.

A legislative definition of the patient's right to refuse treatment should reflect the state's *parens patriae* interest. The Florida court focused on the fact that Perlmutter would not abandon any minor children by his death.[73] The court failed to clarify whether the existence of any financially dependent parties would invoke the *parens patriae* interest. Although the *Saikewicz* court dismissed the *parens patriae* interest by noting that the patient's death would not affect any third parties,[74] this state concern has not previously been limited to the protection of third parties. Both the *Georgetown* and *Quinlan* courts recognized that the *parens patriae* responsibility included a duty of the state to protect disabled patients, and in particular, incompetent patients.[75] In contrast, the instant court refused to consider the effect of incompetency on the state's interest, since that question was not at issue.[76] It may be appropriate for a statute to reflect the *parens patriae* interest with respect to both third parties and incompetent patients.

A legislative treatment of the patient's right to refuse medical care must also encompass the state's interest in protecting the ethical integrity of the medical profession. In the past, states have asserted their interest in encouraging life-sustaining treatment by imposing civil and criminal liability on doctors who allowed their patients to die.[77] The instant court concluded, however, that medical ethics have undergone substantial changes so that deferral to a patient's refusal of treatment is ethically proper in certain circumstances.[78]

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73. See notes 58-59 *supra* and accompanying text.

74. 370 N.E.2d at 427.

75. Determining the best interests of the patient by professional medical testimony, the *Quinlan* court interpreted the *parens patriae* interest as requiring the court to effectuate treatment decisions for the incompetent patient. 70 N.J. at 44, 355 A.2d at 666. Thus, this state interest may weigh in favor of the patient's right of privacy. If the patient cannot competently declare his decision concerning treatment, and medical experts conclude that a competent patient in this position would choose to refuse medical care, the court will not sanction life-prolonging treatment. *Id.* The *Georgetown* court decided, however, that life-prolonging treatment served the best interests of the patient. Thus, in *Georgetown* the *parens patriae* interest dominated the expressed choice to refuse treatment when the patient was judged incompetent to comprehend the consequences of her choice. 331 F.2d at 1008. Similarly, the California Natural Death Act has no provision for enforcing a patient's right to refuse treatment if the patient is not competent after the terminal illness has been diagnosed. *See* CAL. HEALTH & SAFETY CODE §7191(c) (West Cumm. Supp. 1979-80).

76. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162).

77. In the instant case, the State claimed that allowing Mr. Perlmutter to die would be an unlawful killing of a human being under FLA. STAT. §782.04 (1979), or manslaughter under FLA. STAT. §782.08 (1979). Very few cases have imposed liability on doctors for refusing to administer treatment, however. *See* Collester, *supra* note 37, at 310-11. *See also* Hirsch & Donovan, *supra* note 38, at 301.

78. 379 So. 2d at 360 (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 163). Ethical guidelines for life and death decisions have recently received much attention. Some commentators have suggested that physicians should have a set of

As long as these circumstances remain undefined, physicians must decide whether to respect their patients' right to refuse treatment while uncertain of the legal ramifications.[79] While urging such legislative definition, the instant court neither condoned nor condemned enactments such as the California Natural Death Act.[80] The standardized directive[81] may provide the Florida legislature with an exemplary procedural device. However, the recent California statute has had questionable effectiveness in providing patients with a mechanism to exercise their right of privacy.[82] Furthermore, the standardized

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criteria to consistently determine whether there is a quality of life present which creates a duty to sustain the life. H. BRODY, ETHICAL DECISIONS IN MEDICINE 65 (1976). One proposed system is a set of "positive human criteria;" if the patient does not meet any of these criteria, then it is claimed that death is ethically permissible. Fletcher, *Indications of Humanhood: A Tentative Profile of Man,* 2 HASTINGS CENTER REP. 1 (Nov. 1972). Arguably, Mr. Perlmutter met each of the fifteen criteria under this system.

Another scholar on medical ethics has suggested that physicians must consider three distinctions in determining the duty to sustain life: 1) between "ordinary" and "extraordinary" treatment, 2) between prolonging the living of life and prolonging a patient's dying, and 3) between direct killing and merely allowing the patient to die. Ramsey, *On (Only) Caring for the Dying,* in ETHICAL ISSUES IN DEATH AND DYING 189 (R. Weir ed. 1977). The distinction between affirmative killing and passively allowing death, however, has been criticized as arbitrary. *See* Rachels, *Active and Passive Euthanasia,* 292 THE NEW ENGLAND J. OF MED. (1975).

The position of the American Medical Association was stated by its House of Delegates on December 4, 1973: "The intentional termination of the life of one human being by another — mercy killing — is contrary to the policy of the American Medical Association.

The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family." *Id.* at 78.

See generally E. KLUGE, THE PRACTICE OF DEATH 226-44 (1975); T. ODEN, *supra* note 72; P. RAMSEY, ETHICS AT THE EDGES OF LIFE 268-335 (1978); J. WILSON, DEATH BY DECISION 167-95 (1975).

79. While weighing the moral and ethical considerations which are relevant to treatment decisions, physicians must also consider their own potential liability. This burden dilutes considerations of the patient's best interests. Comment, *The Problem of Prolonged Death: Who Should Decide?,* 27 BAYLOR L. REV. 169, 171 (1975).

The Supreme Court of Florida recognized that physicians, public officials, and hospitals needed a definitive statement of the patient's right to refuse treatment as a guide for their conduct. 379 So. 2d at 360. The court noted that fears of liability for treatment decisions could not be discounted because of the absence of any Florida law on this subject. *Id.* (approving the decision of the Fourth District Court of Appeal, 362 So. 2d at 162).

80. See notes 29-33 and accompanying text, *supra.*

81. See text accompanying note 31 *supra.*

82. Some critics have noted that the California Natural Death Act is balanced in favor of the doctor's rights. *See The Right to Die, supra* note 33, at 204. The only incentive for a doctor to honor a patient's directive is the threat of a sanction for unprofessional conduct. *Id.* If a patient fails to re-execute the directive after the diagnosis of a terminal illness, or cannot re-execute because of incompetency, the directive is just one factor in the doctor's decision concerning treatment. *Id.* at 198. Furthermore, a survey conducted thirteen months after the enactment of the statute showed that many doctors were ignorant of the details of the Act, and few were informing their patients of this option. *See An Empirical Study, supra* note 29, at 931-38. The writer concluded, however, that "[t]he survey indicates that the California Natural Death Act has partially achieved its goal of giving terminally ill patients more control over their own treatment." *Id.* at 940.