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In re Living Will

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Abstract

Modern medical technology accords physicians the capacity to prolong life and to protract the duration of numerous incurable diseases.

KEYWORDS: will, living, life

In re Living Will

Modern medical technology accords physicians the capacity to prolong life and to protract the duration of numerous incurable diseases. However, the ability to sustain life transcends the ability to heal. Lives which once would have expired now endure with organ transplants, respirators, pacemakers, and hemodialysis machines. "Living Wills"[1] have been created by lawyers to assist those who wish to avoid mechanically extending their lives. Medical progress, it seems, sometimes creates unforeseen and undesirable consequences.[2]

People envision the horror of being maintained in an unconscious, non-human limbo in a refrigerated room containing only machines. This state is in stark contradiction to the usual idea of death as a brief, but peaceful end. We envision physicians preparing to dissect an organ for transplant from a body whose brain is dead but whose heart is still beating. We also envision a patient having been attached to a respirator for so long that he has developed "respirator brain" — a condition where the brain becomes softened or liquified[3] — destroying pathological indications of brain injury and preventing a determination of the cause of death.[4] Such horrors exist within hospital walls daily, creating confusion and fear among physicians and hospitals in determining whether to withhold or withdraw life-supporting treatment. Since *In re*

1. A "living will" is a document, similar to a will, executed by a person during his lifetime setting forth his wishes concerning medical treatment in contemplation of illness or death.

2. *See* Collester, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304 (1977). *See also* Walker, Diamond & Moseley, *The Neuropathologic Findings in Irreversible Coma*, 34 J. NEUROPATHOLOGY AND EXPERIMENTAL NEUROLOGY 295 (1976).

3. Walker, Diamond & Moseley, *supra* note 2; Wright & Ostrow, *The Role of the Medical Examiner in Determining Time of Death in Brain Dead Patients*, 67 J. FLA. MED. A. 134 (1980).

4. *See* In re Cain, 44 Fla. Supp. 208 (Fla. 4th Cir. Ct. 1976) (the continuation of medical procedures would preclude any possibility of obtaining an effective examination of the deceased woman's brain tissue because such tissue was constantly deteriorating).

Quinlan, the issues of "euthanasia"[5] and "the right to die"[6] have generated controversy in both the medical and legal professions.[7] Reevaluation of the physician's responsibilities to the dying patient has revolved around whether the physician should permit the terminally ill individual to refuse life-supporting treatment or whether he should subsequently withhold or withdraw such treatment. These dilemmas have created a recent flood of interest in the "living will" and in natural death legislation.[8] As a result, many patients questioning the value of prolonging life at the expense of diminishing its quality, are refusing life-supporting treatment, crying "death with dignity."

This right to die by refusing extraordinary treatment has emerged from the recent availability of an alternative to life or death — to be kept "alive" in a limbo state by life-supporting measures. If given the opportunity, a person must be permitted to choose from these alternatives. To many, to die peacefully is a much more attractive alternative than to die with tubes down one's throat and in one's arms.[9] To prolong life at the expense of the loss of bodily functions and intense pain and suffering, absent a hope of cure, does not make the prolongation of life desirable. One such person who shares this belief is the subject of the

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5. Giancola, *The Discontinuation of "Extraordinary" Medical Treatment from a Terminal Patient: A Physician's Civil Liability in New York*, 26 MED. TRIAL TECH. Q. 326, 327 n.6 (1980). Black's defines "euthanasia" as "[t]he act or practice of painlessly putting to death persons suffering from incurable and distressing disease *as an act of mercy*." BLACK'S LAW DICTIONARY 497 (5th ed. 1979) (emphasis added). *See also* J. Sanders, *Euthanasia: None Dare Call It Murder*, 60 J. CRIM. L. CRIMINOLOGY & POLICE SCI. 351 (1969); O. RUSSELL, FREEDOM TO DIE (rev. ed. 1977).

6. *See* Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of In re Quinlan*, 30 RUTGERS L. REV. 267 (1977).

7. In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976) Twenty-one-year-old Karen Quinlan was diagnosed as being in a permanent vegetative state, having lapsed into a coma after an intake of alcohol and drugs. Her father sought to be appointed as her guardian to authorize the withdrawal of extraordinary treatment enabling her to die naturally. This case was the first to determine what constitutes "extraordinary" treatment. Withdrawal of Karen's respirator was permitted by the court. *See* Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 254 (1977); LADIES' HOME J., May, 1980, at 90; TRIAL, September, 1976, at 36; J. LEGAL MED., May, 1976, at 28.

8. *See* Note, *The Right to Die: A Proposal for Natural Death Legislation*, 49 U. CIN. L. REV. 228 (1980).

9. Miami Herald, Apr. 27, 1980, § BR, at 8, col. 1.

following hypothetical case.

Our patient is an elderly man residing in Florida, having moved from California two years ago. He exists in a permanent vegetative state,[10] assisted by a mechanical respirator. Usually, this situation would create all the problems involved in recent cases concerning whether to withdraw life-supporting treatment and allow the patient to die. In such cases, the courts have speculated as to whether the patient would have wanted to die. Usually the patient has never contemplated such a problem, as the average person avoids facing the prospect of dying. However, in this case our patient, while a resident of California, executed a directive, otherwise known as a "living will,"[11] stating that he be allowed to die if he becomes terminally ill or is maintained by extraordinary treatment.

More than four million copies of the living will have been distributed in the past twelve years, mostly in response to individual requests.[12] Lawyers, physicians and hospitals have distributed them to their clients and patients. These living wills are available in legal parchment form or as permanent wallet-size cards. Although the living will is a recognized document, included in *Modern Legal Forms*,[13] the legality of enforcing a living will has never been tested in court. Nevertheless, it remains as an expression of one's right to self-determination over his body, relieving the family and physician of all responsibility for the patient's death.

Our patient's living will stated that "if the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I should be allowed to die and not be kept alive by medications, artificial means or heroic mea-

10. This is a state where the individual has no significant cognitive functions, but may be partially responsive. Cognitive functions include the ability to think, feel, see and communicate. Pollick, *"Cognitive" and "Sapient" - Which Death is the Real Death?* 136 AMER. J. SURGERY 3, 5-6 (1978).

11. The task of considering whether the patient would wish to exercise this right is considerably easier where he has expressed his intent not to have his life prolonged beyond a certain point, especially if he made his "living will" in contemplation of illness or death.

12. 6 Concern For Dying Newsletter 2 (Spring 1980). Forms for "The Living Will" can be obtained by writing, Concern For Dying, 250 West 57th Street, New York, New York 10019.

13. STONE, MODERN LEGAL FORMS § 10199 (Supp. 1980).

sures." Further, the document stated that he was of sound mind, that the document represented his wishes, and that those who carried out his wishes would be free from any liability. His living will included additional provisions concerning transplantation of his organs at death, the names of those persons with whom he had discussed his wishes, and a statement designating what measures he qualified as extraordinary or artificial.

California had passed natural death legislation in 1976 which recognized the right to die in certain situations,[14] but after a decade of futile attempts, Florida had not yet passed such natural death or right to die legislation when our client moved here. Aware of this fact, he reexecuted his living will and distributed copies to his attorney, physician, clergyman, and family. In addition, he carried a minature copy of his living will in his wallet to assure that his wishes would be followed if he were to be found in an unconscious state, unable to express his wishes. A copy of his living will follows:

MY LIVING WILL

This is a declaration of my right to die and a directive that my wishes be carried out.

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14. CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1979):

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

The Legislature further finds that modern medical technology has made possible the artifical prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legaility of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

TO WHOM IT MAY CONCERN

On this *30* day of *March, 1979*, in the city of *Ft. Lauderdale* in the county of *Broward* of the state of *Florida*, I do hereby make known my wishes that I be allowed to die if I should ever encounter a situation where I, as a result of extreme physical or mental disability or incurable illness from which death will follow, have to be or already am being kept alive by such extraordinary or artificial medical treatment as I have described below, and there is little or no chance of my recovery to a cognitive and sapient life according to all current medical knowledge practiced in this community and two physicians, one being my attending physician. If such extraordinary treatment will only serve to artifically prolong my death and not to preserve my life, I request that such procedures be withheld or withdrawn and that I may be permitted to die naturally.

I do hereby make this expression of my wishes voluntarily, being of sound mind and of majority age. I do hereby declare that my physician, upon carrying out my wishes in good faith, shall be immune from civil or criminal liability and not in violation of §782.08 Florida Statutes. If my physician refuses to act in accordance with my wishes, he should direct my care to another physician who will do so.

Additional Provisions

(1) I have discussed my wishes to have life-supporting treatment withheld or withdrawn with the following who understand these wishes:

Jane Doe	(relationship)	wife
Richard Doe	(relationship)	son
May Doe	(relationship)	sister

(2) I consider the following measures of medical treatment extraordinary or artificial; as such, these measures should not be performed upon me:

mechanical respirator
nemodialysis machine
cardiac pacemaker

(3) If any of my organs would be valuable as transplants to help others, I freely give my consent that they be donated for such use, at the point of my legal *and* medical death.

(4) This guarantees that if, any time prior to or at the time of my death, I am competent and wish to change or revoke this living will, I will be allowed to do so in writing or orally in the presence of two persons, one being my physician.

(5) My terminal condition is *diffus cerebral and brain stem anoxia resulting from cardio-respiratory arrest.* This must be completed as the only evidence of a terminal condition. Diagnosed this 20 day of January, 1979 by

John Smith	M.D.
200 Bay Drive	(address)
Oceanview Medical Center	(medical center)

(6) This directive shall have no effect after 5 years from this date unless reexecuted, and it will be my responsibility to see that this is done.

(7) *To the Medical Center:* A copy of this directive shall be made part of my medical records at the medical center at which I am subsequently hospitalized and/or administered such extraordinary treatment.

To the Nursing Home: If I am under care of a nursing home (per Chap. 400 Florida Statutes) at such time as I am required to reexecute my living will, I shall have the assistance of a patient ombudsman (per §400.307 Florida Statutes) for the purpose of preventing undue influence or fraud.

(8) I guarantee that a qualified attorney has inspected this document and is satisfied that all formal requirements of execution have been met.

Signed: /s/ John Doe

We, as witnesses, to vouch for the sound mind of the signer—that he is emotionally and mentally competent and that these are his true wishes and that he signed voluntarily in our presence today, without any undue influence from any physician or family member. We are not in any way whatsoever related to the signer or in any way whatsoever a beneficiary of any interest of the estate of the signer, or in any way whatsoever financially responsible for or involved with the signer's hospitilization.

Witness Shawn Richards
Witness David Adams

Copies of this document have been distributed to the following:

My attorney	Richard Brown, Esquire
address	100 Oceanfront Drive — Ft. Lauderdale, FL
My physician	John Smith, M.D.
address	200 Bay Drive — Ft. Lauderdale, FL
My clergyman	William Jones
address	800 Seagrape Lane — Ft. Lauderdale, FL
My family	Jane Doe
address	100 River Drive — Ft. Lauderdale, FL

Our patient is now in a permanent vegetative state, having lapsed into an irreversible coma following cardio-respiratory arrest. He is being maintained on a respirator. Earlier, his family had agreed to honor his "living will" but now has second thoughts. In addition, his physician now fears criminal liability and refuses to withdraw the extraordinary treatment. Our patient's attorney, who has been an advocate of "right to die" legislation in Florida, presents this case of first impression to the court to determine the legality of this living will.

This case has been predicted in Florida since the recent case of *Satz v. Perlmutter*,[15] wherein the court recognized a patient's right to die. Mr Perlmutter, a competent adult, expressed his wish to discontinue the extraordinary medical treatment which was prolonging his life at the time such treatment was being administered. In contrast Mr. Doe is comatose, incompetent to presently communicate his wishes. Mr. Doe provided for his present situation by previously expressing his wishes in his living will.

Mr. Doe's attorney will attempt to persuade the Florida court to recognize his client's living will and the wishes expressed therein. Since the Supreme Court of Florida arguably recognized a competent patient's right to decide to die, with dignity, expressed in his "contemporaneous living will,"[16] the court should recognize this same right to die with dignity expressed in the patient's previously executed "living will." Mr. Doe is incapable of expressing his wishes contemporaneously with his illness since he is comatose. He expressed his right to die at the only time when he personally could exercise this right; he was competent before the onset of this illness. If incompetents and competents are to be treated equally with regard to their constitutional right to privacy, the court must recognize Mr. Doe's wishes in his living will.

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15. Satz v. Perlmutter, 362 So. 2d 160 (Fla. 4th Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980). The trial court permitted and the Supreme Court upheld the withdrawal of the respirator from Abe Perlmutter, a competent, terminally ill adult who had no minor dependents but had the unanimous approval of his family. *Id. See* Note, *Death with Dignity and the Terminally Ill: The Need for Legislative Action*, 4 NOVA L.J. 257 (1980).

16. 6 Concern For Dying Newsletter 2 (Spring 1980).

DEFINING EXTRAORDINARY TREATMENT

In his living will, our patient refers to heroic or extraordinary measures. What constitutes extraordinary treatment will inevitably affect the outcome of this case. The distinction between extraordinary and ordinary treatment[17] is critical, since judicial decision dictate that a patient is not always free to refuse ordinary treatment when such refusal would affect the patient's death.[18] The court should classify the respirator as extraordinary treatment in conformance with our patient's living will, as it cannot cure his condition but, at best, can only prolong his inevitable death. Therefore, our patient should be free to refuse the treatment.

As medical technology progresses, once extraordinary treatment quickly becomes ordinary treatment. Opposing counsel may argue that we cannot justify withdrawal of the respirator as an extraordinary measure, because it may be considered ordinary tommorow. This argument is without substance, because the courts and physicians must handle the case at the time when it arises. Arguing hypothetical future advances does not solve the instant problems.

This ordinary-extraordinary dichotomy was a determinative issue in *Quinlan*,[19] where the New Jersey Supreme Court had to determine whether a respirator was an extraordinary method of treatment. The court stated:

> [W]hile the record here is somewhat hazy in distinguishing between "ordinary" and "extraordinary" measures, one would have to think that the use of the same respirator or like support could be considered "ordi-

17. Ordinary treatment is usually described as treatment that offers a reasonable benefit without excessive pain, expense or inconvenience. Extraordinary treatment is treatment that offers no reasonable benefit and cannot be used without excessive pain, expense or inconvenience. Hirsh & Donovan, *supra* note 6, at 290.

18. Most cases have involved religious grounds, because patients are almost certain to recover if they accept the treatment. *See* Application of President and Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 331 F.2d 1010 (D.C. Cir. 1964) (the court ordered a blood transfusion against the wishes of the patient—a Jehovah's Witness who had suffered massive blood loss from a ruptured ulcer). *See also* In re Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); In re Osborne, 294 A.2d 372 (D.C. 1972).

19. 70 N.J. at ___, 355 A.2d at 669. *See also* Hirsch & Donovan *supra* note 6, at 290.

> nary" in the context of the possibly curable patient but "extraordinary" in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient.[20]

In certain situations, such as paralytic poliomyelitis,[21] even artifical respiration is not an 'extraordinary' means.

The *Quinlan* court (as well as physicians) lacked guidelines defining extraordinary measures. Unfortunately, it did not set forth any guidelines for use in future situations involving the ordinary versus extraordinary debate.[22] Until recently this distinction largely had been considered of only medical significance. However, the potentiality for criminal prosecutions mandate formulation of distinct legal guidelines. Some Florida legislators have proposed such guidelines, but none have acquired support.[23]

The American Medical Association sanctions 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."[24] The Vatican issued formal declarations in 1957, wherein Pope Pius XII stressed that no obligation exists to use extraordinary means to prolong life or to give a physician permission to use them.[25] In July, 1980, Pope

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20. *Id.* at 48, 355 A.2d at 667-68.

21. Paralytic poliomyelitis: "an acute viral disease, occurring sporadically and in epidemics, and characterized clinically by fever, sore throat, headaches, vomiting, often with stiffness of the neck and back . . . characterized by . . . paralysis." DORLAND'S MEDICAL DICTIONARY 1230 (25th ed. 1974). There may be subsequent atrophy of groups of muscles, ending in contraction and permanent deformity. *Id.*

22. 70 N.J. at 48, 355 A.2d at 667-68.

23. Fla. H.R.J. Res. 91 (1969); Fla. H.R. 3184 (1970); Fla. H.R. 68 (1971); Fla. H.R. 2614 (1972); Fla. H.R. 2830 (1972); Fla. H.R. 407 (1973-74); Fla. H.R.J. Res. 3007 (1974); Fla. H.R. 239 (1975); Fla. H.R. 2463 (1976); Fla. H.R.J. Res. 2575 (1976); Fla. H.R. 3703 (1976); Fla. S. 513 (1976); Fla. H.R. 374 (1977); Fla. H.R. 8 (1978); Fla. H.R. 740 (1979); and Fla. H.R. 463 (1980); Fla. S. 446 (1980).

24. A.M.A. News, Dec., 1973 at 15, col. 2.

25. It is incumbent upon the physician to take all reasonable, ordinary means of restoring the vital functions and consciousness, and to employ such extraordinary means as are available to him to this end. 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—according to the circumstances of persons, places, times, and cultures—that is to say, means that do not involve any grave burden for one-

John Paul II approved a flexible new set of guidelines on euthanasia after consultations with medical experts and moral theologians.[26] Relying on the Catholic teaching that God alone has the right to give life or end it, the Vatican through Pope Paul II nonetheless declared that life need not be prolonged by extraordinary means. When inevitable death is imminent, patients may refuse forms of treatment that would only secure a precarious and burdensome prolongation of life.[27] If there is no duty to deliver extraordinary care to our patient, he must be permitted to have his "plug pulled."

Opposing counsel will interject that we have invented an attractive way out of the dilemma which technology has created, since all technology may be viewed as extraordinary, thereby justifying pulling the plug. In response, we will assure the court that it is not our intention to classify all technology as extraordinary. What is ordinary or extraordinary treatment will vary from patient to patient as medical science progresses.[28] Nevertheless, the law must set guidelines and criteria establishing when medical procedures can be withdrawn. Questions of legality will inevitably surface in the form of homicide, malpractice, and life insurance litigation. Case law on the right to die illustrates that criteria used in determining extraordinary treatment must draw heavily on medical expertise and prevailing medical practices in the community.[29] This court must inject law into this theory; otherwise physicians will be in a position to fashion their own law to prolong life according to customary practices, and this will evoke inconsistency.

RIGHT OF PRIVACY BASIS

Although the United States Constitution does not explicitly recognize a right of privacy, the Supreme Court has recognized its existence

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self 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).

26. NEWSWEEK, July 7, 1980, at 58; TIME, July 7, 1980, at 49.

27. NEWSWEEK, *supra* note 26, at 58.

28. 70 N.J. at 43, 355 A.2d at 667-68.

29. In re Bowman, 94 Wash. 2d 407, 617 P.2d 731 (1980) (en banc); Severns v. Wilmington Medical Center, 421 A.2d 1334 (Del. 1980). Lovato v. District Court In and For Tenth Jud. Dist., 601 P.2d 1072 (Colo. 1979) (en banc).

since *Union Pacific Railroad v. Botsford.*[30] The right of personal privacy has been discussed within the penumbra of specific guarantees of the Bill of Rights,[31] and from language of the first,[32] fourth, fifth,[33] ninth,[34] and fourteenth amendments.[35] The Court's decisions articulate that only personal rights that can be deemed "fundamental" or "implicit" in the concept of "ordered liberty" are included in this guarantee of personal privacy. This constitutional guarantee reached out in *Roe v. Wade*[36] to protect a woman's decision to terminate her pregnancy. The same guarantee extends to preserve one's right to privacy, or common law right of bodily self-determination, against unwanted infringements of bodily integrity in appropriate circumstances.[37]

We would argue that our patient's constitutionally based right of privacy guarantees him the right to reject further medical treatment. The Court in *Superintendent of Belchertown State Schools v. Saikewicz*[38] opined that it was "not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness." The court articulated that a

> constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. That the value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being

30. 141 U.S. 250, 251 (1891).

31. Griswold v. Connecticut, 381 U.S. 479 (1965).

32. Stanley v. Georgia, 394 U.S. 557 (1969).

33. Terry v. Ohio, 392 U.S. 1, 8-9 (1968).

34. 381 U.S. at 484, 486-99.

35. Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

36. Roe v. Wade, 410 U.S. 113, 152 (1973) (a landmark decision where the court declared that a woman's decision to terminate a pregnancy in the first trimester was protected by the constitutionally-guaranteed right of privacy, limited only by a compelling state interest in the preservation of life). Eisenstadt v. Baird, 405 U.S. 438 (1972). Palko v. Connecticut, 302 U.S. 319, 325 (1937).

37. 70 N.J. at ___, 355 A.2d at 663.

38. 373 Mass. 728, 370 N.E.2d 417, 426 (1977). The court upheld the refusal of chemotherapy for acute leukemia for a severely retarded adult and enumerated four state interests: "(1) the preservation of life; (2) the protection of the interest of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession." *Id.* at ___, 370 N.E.2d at 425.

the right of choice.[39]

Recognizing this constitutional right, the court in *Quinlan* noted "that if Karen were herself miraculously lucid for an interval . . . and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death."[40] Karen was in a chronic vegetative state and was assisted in breathing by a respirator. She was able to maintain some internal functions such as body temperature and blood pressure, but she had lost most cognitive brain function. Even though Karen was not able to express a preference for death with dignity over life as a vegetable, the court concluded that no compelling state interest should compel Karen to endure the unendurable.[41]

In 1914, Justice Cardozo mandated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."[42] We propose no interpretation other than that this right incorporate the right to die. Logically, the right to initially refuse treatment is concomitant with the right to discontinue or have such treatment withdrawn once it has been initiated. The individual patient knows his capacity for pain, his family's emotional and financial stability, and his own emotional makeup. In *Eichner v. Dillon*[43] the court asserted that an individual has the right to "control his own person." Therefore, we will argue that our patient's right to privacy will be violated if his body continues to be invaded by these medical procedures.

Courts have limited this right to privacy, restricting conduct which is outweighed by public policy considerations. If the conduct offends the public policy and a substantial state interest exists, the individual's

39. *Id.* at 426.

40. 70 N.J. at 40, 355 A.2d at 663.

41. *Id.*

42. Scholoendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (primarily involved the "informed consent" doctrine).

43. Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980). A priest won judicial approval to withdraw extraordinary, life-supporting treatment (respirator) from Brother Joseph Fox, a 83-year-old religious brother who had lapsed into a permanent vegetative state after a cardiac arrest. The court determined from his prior conversations with Brother Fox that he would want to die in this situation. *Id.*

right to privacy may have to defer to the state interest.[44] In *Saikewicz*, the court enumerated four state interests including:

> 1) the preservation of life;
> 2) the protection of innocent third parties;
> 3) the prevention of suicide;
> 4) the maintenance of true ethical integrity of the medical profession.[45]

The court in *Perlmutter* adopted the four public policy considerations as limitations on the individual's right to privacy.[46] Since *Perlmutter* remains the authority in Florida, we shall demonstrate that we have overcome these limitations.

In *Saikewicz*, the court distinguished between preserving a valuable life and preserving an artificial life (i.e., a brain-dead person in a permanent vegetative state), placing the emphasis on preserving the valuable life.[47] Our terminally ill patient has no life left to preserve. Therefore, no compelling state interest can surmount our patient's right of privacy under the *Roe* test.[48]

Another state interest is the protection of innocent third parties. In Mr. Doe's case, no unborn children are involved as in *Roe* and no minor children as in the *Application of President & Directors of Georgetown College*, where the patient's refusal of treatment would have been an abandonment of his minor child.[49] In *Perlmutter*, the court distinguished its limited decision from *Georgetown*.[50] Even if Mr. Doe had minor children he would not live to support them due to his terminal illness. Therefore, the state has no compelling interest to override our patient's constitutional right to privacy and refusal of medical treatment.

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44. 410 U.S. at 154-55.
45. 373 Mass. at ___, 370 N.E. 2d at 425.
46. 362 So. 2d at 162.
47. 373 Mass. at ___, 370 N.E.2d at 425-26.
48. 410 U.S. at 154. "The right of personal privacy . . . is not unqualified and must be considered against important state interests in regulation. Where certain 'fundamental rights' are involved . . . regulation limiting these rights may be justified only by a 'compelling state interest.'" *Id.* at 155.
49. 331 F.2d at 1008.
50. 362 So. 2d at 162.

The third interest is the state's duty to prevent suicide. We shall adopt *Saikewicz* and argue that if our patient's respirator is disconnected, death will result from natural causes instead of from the respirator's removal.[51] We can negate suicide by demonstrating that our patient did not induce his affliction, and he did wish to live but for his terminal condition. Therefore, there is no compelling state interest in our patient's case.

The final state interest listed by the court in *Saikewicz* was the maintenance of the ethical integrity of the medical practice. *Perlmutter* again adopted the language of *Saikewicz* in its recognition that the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores.[52] Such a doctrine threatens neither the integrity of the medical profession nor the hospital's role in caring for such patients. Therefore, our patient's right of privacy has outweighed these four judicially determined public policy interests.

Reemphasizing, we maintain that the state's interest in preserving life is less when death is merely postponed rather than when life is preserved. The *Quinlan* court declared that the state's interest in the preservation of life diminishes and "the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."[53] In *In re Quackenbush*,[54] the court upheld the patient's right to refuse treatment, the amputation of both legs, since this treatment was an extensive bodily invasion.

In addition, in *Saikewicz*, the court stated that the right of privacy encompasses the right to die;[55] a right with which the state should not interfere in the absence of minor or unborn children and a clear and present danger to the public welfare or morale.[56] In *Georgetown*, the court indicated it would enforce its interest in preserving life and overrule the right of privacy (i.e., right to die) when the bodily invasion ceased, when a reasonable expectation of recovery existed, or when minors or other third parties were involved, whose lives would be jeopard-

51. 373 Mass. at ____, 370 N.E.2d at 421.
52. 362 So. 2d at 163.
53. 70 N.J. at 41, 355 A.2d at 664.
54. In re Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (1978).
55. "To die" is used in the context of a right to refuse non-consensual bodily invasions. 373 Mass. at ____, 370 N.E.2d at 424.
56. *Id.* at ____, 370 N.E.2d at 424-26.

ized by the patient's death.[57] Comparing the incompetent patient in *Eichner* to the first trimester in *Roe*, we reason that both were incapable of independent, meaningful existence. The state's compelling interest in life's preservation only attached when the potential existed for return to a sapient, cognitive life (*Eichner*) or when the fetus was viable (*Roe*). Our patient is terminally ill without hope of returning to a natural existence unaided by artificial life support technology. Therefore our patient should be allowed to die, without artificially prolonging his life.

In affirming *Perlmutter*, the Florida Supreme Court reinforced the district court's decision to limit the case to its facts. *Perlmutter* applies to only competent terminally ill adult patients with no minor dependents and who have the consent of all affected family members.[58] We disagree with the provision requiring familial consent, because the right of privacy is a personal right. As such, we do not advocate the state delegating to third parties its own power to override an individual's right to privacy where this promotes state interests. The adult patient alone should exercise his constitutional right. When the patient is incompetent and unable to exercise this right at the time of his illness, the state should recognize the legality of the living will. Recognizing the expressed wishes contained therein, the state would prevent the exercise of this personal constitutional right by third parties.

In conclusion, we point out the recent passage of House Joint Resolution 387 which created Section 23 of Article I of the Florida State Constitution recognizing a right of privacy.[59] In Florida, the right to die is based on the right of privacy; therefore, this recent constitutional amendment supports the right to die naturally and the right to refuse prolongation of life through artificial means.

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57. 331 F.2d at 1000.

58. 379 So. 2d at 359 (affirming lower court's ruling upholding patient's right to refuse medical treatment).

59. Fla. H.R.J. Res. 387, (1980) (approved by voters in the November, 1980, general election.) "Right of Privacy: Every natural person has the right to be let alone and free from governmental intrusion into this private life except as otherwise provided herein. . . ." FLA. CONST. art. I, § 23.

FLORIDA'S BRAIN DEATH STATUTE[60]

An issue that confronts many courts is when life-supporting measures can be terminated. The law has always adopted the medical definition of death.[61] However, in light of recent medical developments, the legal definition of death is changing and the old "heart-lung death" definition is outmoded.[62]

The medical profession's current definition dictates that if the brain is dead the patient is dead, even though a patient's vital organs

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60. FLA. STAT § 382.085 (Supp. 1980) provides:

Recognition of brain death.

(1) For legal and medical purposes, where respiratory and circulatory functions are maintained by artificial means of support so as to preclude a determination that these functions have ceased, the occurrence of death may be determined where there is the irreversible cessation of the functioning of the entire brain, including the brain stem, determined in accordance with this section.

(2) Determination of death pursuant to this section shall be made in accordance with currently accepted reasonable medical standards by two physicians licensed under chapter 458 or chapter 459. One physician shall be the treating physician, and the other physician shall be a board-eligible or board-certified neurologist, neurosurgeon, internist, pediatrician, surgeon or anesthesiologist.

(3) The next of kin of the patient shall be notified as soon as practicable of the procedures to determine death under this act. The medical records shall reflect such notice; if such notice has not been given the medical records shall reflect the attempts to identify and notify the next of kin.

(4) No recovery shall be allowed nor criminal proceedings be instituted in any court in this state against a physician or licensed medical facility that makes a determination of death in accordance with this section or which acts in reliance thereon, if such determination is made in accordance with the accepted standard of care for such physician or facility as set forth in s. 768.45. Except for a diagnosis of brain death, the standard set forth in this section is not the exclusive standard for determining death or for the withdrawal of life support systems.

An analysis of several states' brain death statutes can be found in the note, *Toward a Legally and Medically Acceptable Definition of Death*, immediately following this paper.

61. BLACK'S LAW DICTIONARY 360 (5th ed. 1979) defines "death" as "[t]he cessation of life, the ceasing to exist, defined by physicians as a total stoppage of the circulation of blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc."

62. M. Green & D. Wikler, *Brain Death and Personal Identity*, 9 PHILOSOPHY AND PUBLIC AFFAIRS 105 (1980).

are maintained by machinery.[63] Brain death is the state when an individual has no reflexes other than spinal reflexes, a flat electroencephalogram (EEG) indicating a complete absence of purposeful electrical activity in the cortex, and no capacity to breathe on his own.[64] This discrepancy between the positions of law and medicine on the definition of death places physicians in the precarious position of facing possible criminal sanctions under the legal definition of death. The "heart-lung death" concept can no longer remain valid in light of modern resuscitative technology, which can virtually revive even those with no chance of survival. Recent developments in the area of transplants[65] have created a demand for organs which have been removed after the donor's death, but before the death of the tissues. As a result, a concern to pinpoint the precise time of death has emerged.

Physicians adhere to the brain death[66] definition in order to proceed with transplants while the vital organs are maintainable by machinery, thereby facilitating and increasing the number of possible transplants. Physicians, however, may be criminally guilty of homicide, if the law retains the "heart-lung death" definition of death. If surgeons are required to wait until the heart stops the donor may be "legally dead," but the organs may be worthless for transplants.

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63. In re Bowman, 94 Wash. 2d 407, 617 P.2d 731, 733 (1980) (en banc).

64. *Id.*

65. *See* F. Stuart, *Progress In Legal Definition of Brain Death and Consent to Remove Cadaver Organs*, 81 SURGERY 68 (1977); Note, *The Criteria For Determining Death in Vital Organ Transplants - A Medico-Legal Dilemma*, 38 MO. L. REV. 220 (1973).

66. In Lovator v. District Court, ___ Colo. ___, 601 P.2d 1072 (1979) the court defined brain death under the Uniform Brain Death Act: "For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem is dead." *Id.* at ___, 601 P.2d at 1080.

"Characteristics of brain death consist of: (1) unreceptivity and unresponsiveness to externally applied stimuli and internal needs; (2) no spontaneous movements or breathing; (3) no reflex activity; and (4) a flat electroencephalogram reading after a 24 hour period of observation. Comm. v. Golston, ___ Mass. ___, 366 N.E.2d 744 (1977). An increasing number of states have adopted this so-called "Harvard" definition of brain death, either by statute or court decision." BLACK'S LAW DICTIONARY 170 (5th ed. 1979). *See also* M. Green & D. Wikler, *supra* note 62; 238 J. A.M.A. 1651-55 (1977); 238 J. A.M.A. 1744-48 (1977); P. Green, *Brain Death*, 78 WIS. MED. J. 13 (1979); *Status of the Legal Definition of Death*, 5 NEUROSURGERY 535 (1979); Brain Death, *supra.*

The growing need for transplant organs alone does not justify declaring "death" perfunctorily. Physicians need a brain death standard for uniformity so they can make legal as well as wise medical decisions. Courts, scrutinizing physicians' conduct, have found that extraordinary treatment was continued on terminal patients, in substantial part, due to the increasing proliferation of malpractice litigation and possible criminal liability.[67] Physicians have been heard to say, "Let's not pull the plug," fearing criminal liability. Thus, legal concerns rather than a patient's best medical interest may dictate a physician's actions.

Preeminent medical panels have posted new death criteria for resolving the dilemma spawned by recent technological advances. In 1968, the Ad Hoc Committee of the Harvard Medical School adopted the "permanent cessation of brain function" as the definition of death.[68]

Criteria used in diagnosing a patient as "brain dead," include the following:

(1) pupils fixed and dilated;

(2) no extraocular movements, evident by using caloric testing or doll's eyes;[69]

(3) no spontaneous respiration without a ventilator;

(4) no motor or sensory response to neurologic testing;

(5) patient completely flexic;[70] and

(6) no normal cerebral activity evident on the EEG.[71]

The question then arises whether the patient is "legally" dead though the heart continues to beat. If in all brain dead patients who are

67. G. Annas, *Reconciling Quinlan and Saikewicz: Decision-Making for the Terminally Ill and Incompetent*, 4 AMER. J. L. & MED. 367, 395 (1979).

68. *See* Meyer v. Nebraska, 262 U.S. 390 (1923); *A Definition of Irreversible Coma*, 205 J. A.M.A. 85 (1968).

69. Doll's eyes is an oculocephalic reflex. P. Green, *supra* note 66, at 17. 5 CLINICAL NUCLEAR MED. 152 (April 1980).

70. Flexic means the absence of reflexes. C. Nagle, *Use of Immediate Stutic Scans in Combination with Radionuclide Cerebral Angiography as a Confirmatory Test in the Diagnosis of Brain Death. See An Appraisal of the Criteria of Cerebral Death*, 237 J. A.M.A. 982 (1977).

71. Electroencephalogram (EEG): "An EEG reading is obtained by attaching electrodes to the patients' head and examining the brain wave on a monitor." Comment, *The Criteria For Determining Death in Vital Organ Transplants - A Medico-Legal Dilemma*, 38 MO. L. REV. 220, 224 n.24 (1973).

not being sustained by a respirator, their hearts will not beat and in all brain death patients who are being assisted by a respirator, their hearts do beat, logic dictates that the respirator keeps the heart beating, not life. A machine can create an artificial heartbeat. Thus, these patients are not medically "alive." Why should these patients be legally alive, when not medically alive? These differences must be reconciled. The traditional definition of death was formulated when a heartbeat could not be artifically sustained.

The most recent test for determining brain death is a radionuclide cerebral angiogram (RCA).[72] In this test, isotope angiography reveals the condition of the vessels supplying blood to the brain. The absence of intracranial blood flow on the dynamic RCA, caused by the lack of uptake in cerebral sinuses, confirms a diagnosis of brain-death. RCA enjoys a distinct advantage over other tests for determining brain death. The results obtained by a RCA are not affected by drugs. Other tests (utilizing an EEG) do not determine brain death as accurately in a patient whose coma is due to drug intoxication.[73] Studies show that it is still possible to resuscitate an unconscious patient (due to an overdose of sedatives, tranquilizers, narcotics, or hypothermia) for up to six hours after the appearance of a flat EEG.[74] Therefore, the RCA is a major step forward in determining brain death and in contributing to one "medico-legal" definition of death.

While the guidelines for determining death may differ with the particular test, all require repeated determinations or reexaminations after specified time intervals. Despite the growing recognition among physicans of the brain death test, confusion is prevelant. Physicians, faced with the recent surge of medical malpractice litigation, need set standards promoting uniformity to conform their medical decisions to legal standards.

Since 1971, twenty-six states have enacted statutory definitions of brain death.[75] In 1978, the National Conference of Commissioners on

72. RCA is an x-ray visualization of the vascular system of the brain. *See Triage in Patient Care*, 8 HEART & LUNG 1103, 1105 (1979).

73. *Appraisal, supra* note 71.

74. *Id.*

75. 1979 ALA. ACTS 165; ALASKA STAT. § 09.65.120 (Supp. 1979); ARK. STAT. ANN. § 82-537 (1977); CAL. HEALTH & SAFETY CODE § 7180 (Deering 1975); CONN. PUBLIC ACT 79-556; GA. CODE § 88-1715.1 (1975); HAWAII REV. STAT. § 327C-1

Uniform State Laws approved the "Uniform Brain Death Act" which provides that "[f]or legal and medical purposes an individual who has sustained irreversible cessation of all functioning[76] of the brain, including the brain stem, is dead."[77]

In Florida, in 1980, a brain death bill[78] was introduced at the request of certain hospitals. This bill, which became law on October 1, 1980, states that death is to be determined where there is irreversible cessation of the functioning of the entire brain, including the brain stem. It further states that for legal and medical purposes a determination of death is to be made where respiratory and circulatory functions are maintainable only by artificial means of support. It maintains that no criminal proceedings will be instituted in any court in this state against any physician or medical facility making a determination of death in accordance with this statute. It warns that brain-death is not the exclusive standard for determining death or the withdrawal of life-supporting systems.[79] We maintain that our patient is both legally and medically dead, and therefore the physician should disconnect the respirator.

THE PHYSICIAN'S ROLE

The physician, in our case, fears criminal sanctions if he carries out the patient's wishes to have treatment withdrawn as the legality of

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(Supp. 1980); IDAHO CODE § 54-1819 (1979); ILL. ANN. STAT. ch. 3, § 552 (Smith-Hurd Supp. 1975); IOWA CODE § 702.8 (West 1979); KAN. STAT. ANN. § 77-202 (Supp. 1979); LA. CIV. CODE ANN. art. 9-111 (West Supp. 1979); MD. ANN. CODE art. 43, § 54F (1980); MICH. COMP. LAWS § 333.1021 (1980); MONT. REV. CODES ANN. § 50-22-101 (1979); NEV. REV. STATS. § 451.007 (1979); N.M. STAT. ANN. § 12-2-4 (Supp. 1973); N.C. GEN. STAT. § 90-322 (Cum. Supp. 1979); OKLA. STAT. tit. 63 § 1-301 (1976); OR. REV. STAT. § 146.087 (1977); TENN. CODE ANN. 53-459 (1977); TEX. REV. CIV. STAT. ANN. § 4447t (Vernon Supp. 1980); VA. CODE § 54-325.7 (Supp. 1980); W. VA. CODE § 16-19-1 (Supp. 1980); WYO. STAT. § 35-19-101 (Supp. 1980); and Fla. S.B. 293.

76. "Functioning" meaning purposeful activity in all parts of the brain, as distinguished from random activity. M. Green, *supra* note 69.

77. Lovato, ___ Colo. at ___, 601 P.2d at 1080.

78. Fla. S. 293 FLA. STAT. § 832.085 (Supp. 1980). *See* note 60 *supra* for the text of FLA. STAT. § 382.085 (Supp. 1980).

79. Fla. S.B. 293 (1980).

the "living will" has not yet been determined in this state. With the rise in malpractice suits, physicians have had to be extremely cautious as well as secretive in their actions. In 1961, a survey conducted at a Chicago medical convention revealed that more than half of the physicians present believed euthanasia was being practiced by members of the profession.[80] In testimony before a 1974 Senate subcommittee,[81] it was revealed that about three-fourths of American physicians practiced passive euthanasia regularly, that is, they withdrew artificial life support, permitting the patients to die.[82]

In *Quinlan*, it was acknowledged that it was not unusual in the medical community for physicians to terminate or withhold extraordinary treatment in terminal cases without resort to the law.[83] Few physicians have been prosecuted for such actions and fewer have been convicted. Therefore, legislation could only have a positive effect, for the state of affairs as it now exists is without controls, and is insufferable.

We do not question the state's undoubted power to punish the taking of human life, but that power should not prevent an individual from refusing medical treatment pursuant to his right to privacy. In *Perlmutter*, it was argued that the patient's ensuing death should not be classified as homicide, but rather death from existing natural causes. Since the patient was sustained by a respirator, its withdrawal left the patient's system in control and death would ensue naturally.[84] In *Quinlan*, the court determined that the termination of treatment was lawful because it was justifiable under the circumstances.[85] Therefore, the termination of our patient's treatment could not be considered "unlawful."

The advantages of the living will are obvious. If a physician were

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80. *Voluntary Mercy Death*, 8 J. FOR. MED. 57, 68 (1961).

81. *Medical Ethics: The Right to Survival: Hearings Before the Subcommittee on Health of the Comm. on Labor and Public Welfare*, 93d Cong., 2d Sess. 9 (1974).

82. *Id.*

83. 70 N.J. at 42, 355 A.2d at 667. *See* Horan, *The "Right to Die" Legislative and Judicial Developments*, 13 FORUM 488 (1978).

84. 362 So. 2d at 1.

85. 70 N.J. at 43, 355 A.2d at 668. 394 U.S. at 559. In Florida, it is a felony to assist another in the commission of self-murder. "Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree. . . ." FLA. STAT. § 782.08 (1979).

prosecuted for permitting a patient to die when that patient's life could have been prolonged by extraordinary treatment, the physician would have a strong defense in the living will. On the other hand, if the physician refused to honor the living will and maintained the patient on extraordinary treatment, the physician might be sued more successfully for pain, suffering, and expense caused by the unauthorized treatment.[86] Our patient's living will will give renewed confidence to all physicians and family members performing in accordance with its provisions.

LITIGATION V. LEGISLATION

Court decisions in the past six years have substantially supported the patient's right to refuse treatment. This right must be accepted by the legal and medical professions, in order that it might be invoked without the delay and uncertainty involved in seeking judicial approval.[87]

The *Perlmutter* case determined that the issue of the right to die was more suitable for the state legislature.[88] Proponents stress that the legislature is more capable of investigating and synthesizing the facts and opinions that may be relevant to the resolution of such a complex legal, medical, and social issue. In addition, a legislative directive would eliminate the problem of uniformity inherent in a case-by-case approach to the problem. Critics of natural death legislation fear that after the living will is legalized, enabling passive euthanasia to be practiced, the next step would be the legalization of active euthanisia.[89] They maintain that while the withdrawal of life-supporting treatment can be rationalized under existing legal doctrines, the authorization of

86. Courts have uniformly held that it is an assault and battery upon a person to administer medical treatment that he does not want. Trogun v. Fruchtman, 58 Wis. 2d 596, 207 N.W.2d 297, 310 (1973). Mohr v. Williams, 95 Minn. 261, 271, 104 N.W. 12, 16 (1905). Scholoendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

87. The Quinlan court stressed that "termination of treatment" should not require prior judicial determination. 70 N.J. at 50, 355 A.2d at 669.

88. 379 So. 2d at 360.

89. N. Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243 (1977). G. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967).

active euthanasia would obviously require a revision of current criminal law.[90]

There is also concern that these acts will create more problems than they solve by inhibiting other lawful withdrawal of life-supporting treatment, unless such a document has been executed by the patient. Another concern is that physicians' diagnoses can be fallible and patients can experience spontaneous remissions.[91] Nonetheless, these concerns have been addressed in the statutes and safeguards have been instituted to decrease their occurrence.[92]

Since the *Quinlan* case, nearly all state legislatures have been presented with natural death bills. The first living will statute was enacted in California in 1976,[93] followed by seven others in 1977[94] and two in 1979.[95]

Our case has come before the Florida judiciary since the legislature has not acted. For the past decade, it has rejected death with dignity legislation.[96] As a result the Florida courts must take the lead in establishing the law in this area. Legislative inaction must not prevent judical enforcement of constitutional rights.[97]

The three latest cases[98] in this area promote the need for judicial recognition of the living will. In *In re Spring*,[99] the court emphasized

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90. N. Cantor, *supra* note 89; G. Fletcher, *supra* note 89.

91. Ironically, Karen Quinlan is still alive in a nursing home three years after her respirator was disconnected.

92. KAN. STAT. §§ 61-28, 102-28, 103 (Supp. 1979).

93. CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Supp. 1980).

94. ARK. STAT. ANN. § 82-301-3804 (Supp. 1977). IDAHO CODE §§ 39-4501-4508 (Supp. 1980). NEV. REV. STAT. §§ 449.540-.690 (1977). N.M. STAT. ANN. §§ 24-7-1 to -11 (1978). N.C. GEN. STAT. §§ 90-320 to -323 (Supp. 1979). OR. REV. STAT. §§ 97.050-.090 (1977). TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1980).

95. KAN. STAT. § 65-28, 101 & 65-28, 109 (Supp. 1979). Ch. 112, 1979 WASH. LAWS (to be codified at WASH. REV. CODE ch. 70).

96. See note 23 *supra* and accompanying text.

97. As the *Perlmutter* court stated: "Preference for legislative treatment cannot shackle the courts when legally protected interests are at stake. . . . Legislative inaction cannot serve to close the doors of the courtrooms of this state to its citizens who assert cognizable constitutional rights."

98. In re Spring, ___ Mass. ___, 405 N.E.2d 115 (1980). Eichner v. Dillon, ___ A.D.2d ___, 424 N.Y.S.2d 517 (1980). In re Yetter, 62 Pa. D. & C.2d 619 (1973).

99. ___ Mass. at ___, 405 N.E.2d at 115.

that the "living will" responds to the wishes of patients who have chronic disease which would be fatal if not for modern medical technology.

The court in *In re Yetter*[100] enforced an oral expression of an incompetent patient made while she was competent, requesting that she not be treated for terminal illness. The court determined that if she were competent at this moment, she would want the life-supporting treatment terminated.

In *Eichner v. Dillon*,[101] Brother Joseph Fox, an 83-year-old incompetent patient, had expressed his wish for a natural death prior to becoming incompetent. The Supreme Court cited this expression as evidence in a decision upholding the lower court's order to terminate respiratory treatment. Unfortunately, Brother Joseph lapsed into a vegetative state after suffering a cardiac arrest and died of congestive heart failure before the opinion was handed down. Brother Joseph had expressed his wishes to Father Eichner and Father Keenan just prior to hospitalization, stating that if he should enter into a state where his brain was rendered permanently incapable of sapient and rational thought, the use of extraordinary life support systems should be discontinued and nature allowed to take its course.

Recognizing these previously expressed oral directives can create tremendous hearsay problems. By adopting such a practice the court would be forced to play a guessing game as to the patient's wishes if competent.

Although living will legislation is a good idea, it has produced difficulties which will undoubtedly be ironed out in time. The North Carolina statute states that once a patient has been declared dead, consent of the family is required to stop treatment.[102] The Arkansas statute provides for a list of relatives who can execute a living will for an incompetent patient.[103] One can envision an unknown relative being empowered with the right to make this rather delicate decision. The California statute requires the physician to determine the validity of the living will, a cumbersome and unfair burden to the physician.[104] In

100. 62 Pa. D. & C.2d at 620.
101. ___ A.D.2d at ___, 424 N.Y.S.2d at 519 (1980).
102. *See* statutes cited in note 94 *supra*.
103. *Id.*
104. *See* CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Supp. 1980).

Kansas, the physician can presume that the consent is valid if he has no knowledge to the contrary.[105] These matters could be solved through the creation of one uniform living will to be copied in all states, providing for flexibility in the addition of clauses such as the individual's desire to donate organs for medical research.

Many feel that informed consent to refuse treatment cannot be given years before the patient confronts any terminal illness, when the patient is in perfect health. However, wills to dispense of estates are made years before death. Perhaps to compensate for changes in circumstances or feelings of the patient, we should provide for a codicil, much like that for a will. Some states recommend that the living will be reexecuted every set number of years to demonstrate that the patient's intentions have not changed.[106]

On the other hand, proponents of these advance declarations feel that with the mental and physical duress of a terminal illness, the consent may not be rational. While a contemporaneous declaration may be the logical preference as in *Perlmutter*, the patient must be allowed to exercise his constitutional right to refuse treatment in advance by written directive, as he may never have the opportunity after falling ill.

SOLUTION: THE LIVING WILL

This court did not have to speculate as to our patient's wishes, since they were enumerated in his living will. As our patient commands a constitutional right to refuse treatment, his living will, in efffect, merely establishes in advance those wishes which he could have effected legally under *Perlmutter*, at the discovery of his terminal illness, were he conscious and capable of expressing his wishes. The living will is destined to be a meaningful and legally recognized manner of providing for future events that directly affect one's right to privacy. Despite a decade of failure by the Florida Legislature to enact any natural

105. KAN. STAT. § 65-28, 101 & 65-28, 109 (Supp. 1979).
106. Those states are California, Idaho and Oregon. *See* notes 93 & 94 *supra.*

death legislation, courts should find the living will legally valid as the first step toward inducing such legislation.

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