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The Advance Directive Statute Revisited

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NOTES & COMMENTS

The Advance Directive Statute Revisited

SAMUEL W. WARDLE¹

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I. ABSTRACT

State regulation of end-of-life care is about nothing more or less than the government's relationship to its citizens' most intimate personal choices. And while most people agree, at least superficially, that individuals should be free to refuse futile and painful medical treatment, this area of the law is nevertheless fraught with tension and difficulty. On one hand, individuals prefer autonomy from state intrusion. Yet, on the other, the government should have a clear and effective role in protecting the vulnerable.

These dueling goals raise hard questions. What should a physician do if a terminally ill patient seems to be acting out of despair, and not measured consideration? What if a patient is unconscious and incapable of relaying her wishes? What if the unconscious patient executed a liv-

1. J.D. Candidate 2013, University of Miami School of Law. I greatly appreciate the help of my advisor, Dean Patricia White, as well as the advice of Karon Coleman, former Assistant Miami-Dade County Attorney for Jackson Memorial Hospital, and Professor Kenneth Goodman, director of the University of Miami's Bioethics Program.

ing will, but the language of the living will is ambiguous? What if a patient's family members disagree with his choice?

Florida's highest court has looked to the Florida Constitution's explicit right of privacy as the solution to these difficulties. The Florida Supreme Court, in every end-of-life decision it has published, has affirmed that patients have a right to refuse medical care, including medical care necessary to save or prolong their lives. This broad, categorical authority to refuse treatment goes several steps farther than the constitutional decisions of the United States Supreme Court.

The Florida legislature, concerned that the Florida Supreme Court went too far, approached the conundrum of end-of-life care from a different ethical point of view—protection of the vulnerable. The Florida Advance Directive Statute, amended to its current form in 1999, attempts a compromise between the court's autonomy-oriented jurisprudence and social conservatives' concern with euthanasia and assisted suicide. Unfortunately (and tragically for many Floridians), the legislature's attempt at compromise was hasty and ill-conceived, and resulted in a confusing statute that tramples patient autonomy, while failing to effectively protect the vulnerable.

The Advance Directive Statute's drafters invented a bright-line restriction on patient autonomy that contradicts the constitutional decisions of the Florida Supreme Court. The statute, in its current form, holds that life support may never be removed from a patient, regardless of the clarity of the patient's wishes, the advice of his or her doctor, or the consensus of his or her family, unless two doctors determine that the patient (1) has a "terminal condition," (2) has an "end-stage condition," or (3) is in a "persistent vegetative state."

This Comment argues that the terminal/ end-stage/ persistent vegetative state categories contradict the Florida Supreme Court's constitutional cases on the right of critically ill patients to refuse hopeless treatment. The categories' largest problem lies in their vagueness—these are imprecise clinical criteria that the statute's drafters did not fully understand, and indeed that doctors, patients, and courts also struggle with. As a result, the categories draw the attention of medical and legal decision-makers away from patient intent, and toward an evaluation of whether a patient fits within the terminal/ end-stage/ persistent vegetative state framework.

The legislature's statutory *léger de main* poses two perverse consequences. First, for patients in what is arguably a terminal or end-stage condition, disagreement over the applicability of the terms can, at best, raise the specter of protracted litigation, and at worst, nullify an otherwise valid living will. Second, the legislature's poor choice of drafting

language also has the unintended effect—tragically demonstrated in the Terri Schiavo case—of encouraging the removal of life support from persistently vegetative patients whose intent is difficult, if not impossible, to ascertain.

II. INTRODUCTION: FLORIDA'S CONSTITUTIONAL RIGHT TO REFUSE MEDICAL TREATMENT

Estelle Browning enjoyed remarkable health.² The only ailment she suffered, well into her 80s, was high blood pressure.³ She outlived her husband by more than a decade.⁴ In fact, at the time of her death, she had outlived all her relatives except for an octogenarian second cousin.⁵ She was, by all recorded accounts, a happy woman.⁶

In her 85th year, Mrs. Browning stopped by a nursing home to visit friends.⁷ Two days later, she spoke to her confidante, Rose Kings, about the sick and incapacitated patients she had seen. "Oh Lord," Mrs. Browning told Ms. Kings, "I hope this never happens to me."⁸

Mrs. Browning had already drafted a living will. She requested, in writing, that she not be kept alive artificially if she lost consciousness and had no hope of recovery.⁹ Yet, out of an abundance of caution, Mrs. Browning executed a second living will, stipulating the following:

If at any time I should have a terminal condition and if my attending physician has determined that there can be no recovery from such condition and that my death is imminent, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.¹⁰

"Thank God I've got this taken care of," Mrs. Browning told Ms. Kings. "I can go in peace when my time comes."¹¹

A year after her conversation with Ms. Kings, Mrs. Browning suffered a stroke.¹² The stroke caused irreparable damage to the portion of

2. Herbert *ex rel.* Browning v. State (*In re* Guardianship of Browning), 543 So. 2d 258, 261 (Fla. Dist. Ct. App. 1989) [hereinafter Browning I], *aff'd*, 568 So. 2d 4 (Fla. 1990).

3. *Id.*

4. Mrs. Browning's husband died in 1978. *Id.* Mrs. Browning died July 16, 1989, outliving her husband by eleven years. State v. Herbert (Guardianship of Browning), 568 So. 2d 4, n.1 (Fla. 1990) [hereinafter Browning II].

5. *Browning I*, 543 So. 2d at 261.

6. *Id.*

7. *Browning II*, 568 So. 2d at 8.

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.* at 8–9.

12. *Id.* at 8.

Mrs. Browning's brain that controls conscious thought, and left her paralyzed, unaware, and incapable of swallowing on her own.¹³ Her doctors surgically grafted a feeding tube into her stomach, and transferred her to a nursing home.¹⁴ Over the months that followed, physical problems plagued Mrs. Browning, including instances in which her gastrostomy tube fell out of her stomach.¹⁵ Doctors inserted a second tube through her mouth.¹⁶ Yet, Mrs. Browning's condition was stable. She was permanently incapacitated and unlikely to ever recover, but her doctors predicted that she could live, with life support, for years to come.

A. *The Constitutional, Ethical, and Practical Challenges of Regulating Living Wills*

Most Americans, like Mrs. Browning, say they would prefer a natural death over the prolonged misery of artificial life support.¹⁷ But that widely held sentiment—while understandable—belies the practical, ethical, and constitutional difficulties of whether to remove a patient's life support. In the practical realm, the scope of difficulties is nearly endless. How should a hospital implement a vague living will? How specific should a court require that a living will be? And what course of action should doctors take with an unconscious patient who has no living will or family members?

Further, two distinct categories of ethical issues arise in end-of-life care. First, courts and legislatures must adequately distinguish between allowing a patient to refuse additional care, and promoting physician-assisted suicide. Patient autonomy is a good thing; euthanasia and suicide are not.¹⁸ Second, judges and healthcare professionals generally should not be in the business of substituting their own conceptions of

13. *Browning I*, 543 So. 2d at 261.

14. *Browning II*, 568 So. 2d at 8.

15. *Id.*

16. *Id.*

17. Lois Shepherd, *State Legislative Proposals Following Schiavo: What Are They Thinking?*, 15 TEMP. POL. & CIV. RTS. L. REV. 361, 375 (2006).

18. In the criminal law context, the line between criminal "medical murder" and permissible removal of medical treatment is by no means clear. In the influential California decision *Barber v. Superior Court*, for example, the state charged doctors with murder after they removed life support from a comatose patient, at the request of the patient's family. 147 Cal. App. 3d 1006 (Ct. App. 1983). The *Barber* court analyzed the charge in the familiar criminal paradigm of act versus omission, and determined that the removal of medical care was an omission, rather than an affirmative act. *Id.* at 1015–17. The court went on to determine that the doctors had no criminal-law duty to provide invasive medical treatment whose burdens outweighed its benefits to the patient. *Id.* at 1019–20. The *Barber* court's approach has been criticized as theoretically unsound, because it resorted to legal technicalities to skirt the basic fact that the removal of life support caused the patient's death, regardless of the exact chain of events. See Arthur Leavens, *A Causation Approach to Criminal Omissions*, 76 CAL. L. REV. 547, 586–87 (1988).

what a reasonable patient would want for the patient's own expressed wishes.¹⁹

Ever since end-of-life care moved from the province of the home to that of the hospital, courts have struggled to address these practical and ethical problems while respecting constitutional notions of patient dignity and autonomy.²⁰ Here, the ultimate question is the permissible degree of government involvement in a deeply personal choice—in other words, how much leeway should governments have in enforcing their own ethical and practical priorities, at the expense of patient autonomy? Florida's answer diverges somewhat from that given by the United States Supreme Court.

On the federal level, the nation's highest court has not gone so far as to declare an absolute "right" to refuse treatment. Rather, the Supreme Court has held that various zones of privacy inherent in the Bill of Rights imply a "liberty interest" in refusing unwanted medical interventions.²¹ The Florida Supreme Court, on the other hand, has provided a clearer and more definitive answer.

In a line of cases going from the late 1970s to the early 1990s, the Florida Supreme Court has consistently articulated a powerful and nearly inviolate right to refuse medical treatment.²² This line can be traced to the seminal 1980 decision of *Satz v. Perlmutter*, in which the court held that a dying man who could express his desire to withdraw from treatment had a constitutional right for that desire to be respected.²³ *Perlmutter* was followed in 1984 by *John F. Kennedy Memorial v. Blud-*

19. Practical considerations in the drafting and implementation of living wills have received a great deal of thoughtful treatment in legal literature. See, e.g., Patricia D. White, *Appointing a Proxy Under the Best of Circumstances*, 1992 UTAH L. REV. 849, 857–58 (1992). Indeed, the Florida Advance Directive Statute, which is the subject of this Comment, has seen its fair share of devastating practical critiques. See, e.g., Anita Cava, *Advance Directives: Taking Control of End-of-Life Decisions*, 14 ST. THOMAS L. REV. 5, 9 (2001); Kenneth W. Goodman, *Commentary: National Living Wills and Local Politics*, ASBH EXCH. (Am. Soc'y for Bioethics & Humanities), Summer 1999, at 6; Kenneth W. Goodman, *Persistent Legislative State: Law, Education, and the Well-Intentioned Healthcare Ethics Committee*, 13 HEALTHCARE ETHICS COMMITTEE F. 32, 34–35 (2001). And though these practical and ethical issues cannot and should not be entirely absent from any discussion of living wills, it is not the purpose of this Comment to delve too deeply into subjects that have been more fully considered elsewhere. Rather, this Comment focuses on the Advance Directive Statute's constitutional problems.

20. See Norman L. Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182 (2001).

21. *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 278 (1990).

22. Barbara A. Noah, *Politicizing the End of Life: Lessons from the Schiavo Controversy*, 59 U. MIAMI L. REV. 107, 110 (2004) ("It is a well-settled principle under Florida law that individuals have a right to refuse life-sustaining medical treatment. In fact, the combination of Florida's constitution, statutes, and case law appears more clearly protective of a right to refuse such treatment than the federal due process standard discussed in *Cruzan*.").

23. *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980).

worth, which extended the right to refuse treatment to vegetative patients with no hope of recovery.²⁴ *Browning* then explicitly extended that right to all patients who have lost the ability to verbally express their wishes.²⁵ The only constitutionally-permissible restrictions on the exercise of this right, as described in more detail below, are state interests and clear evidence of a patient's wishes for his or her end-of-life care.

Florida's right to refuse care has proven resilient, and has survived difficult cases. For example, in 1993, the Florida Supreme Court held that Patricia Dubreuil had a right to refuse a blood transfusion necessary to save her life after a caesarean section, even though her death would leave her four children—including her newborn—without a mother.²⁶ Subsequent Florida appellate courts have interpreted *Dubreuil* and its predecessors to amount to a "categorical authority" to refuse medical treatment.²⁷ This is a far sight more definitive than the federal "liberty interest" in refusing unwanted treatment.

The difference between the approaches taken by the Florida Supreme Court and the United States Supreme Court is easily explained. The Florida Supreme Court grounded its decision in the Florida Constitution's explicit right to privacy, which provides that "[e]very natural person has the right to be let alone and free from governmental intrusion into the person's private life"²⁸ There is no comparable provision in the United States Constitution, leaving the federal courts to cast about for "penumbras" and "emanations" of liberty that create vaguer "zones" of privacy.²⁹

24. *John F. Kennedy Mem'l Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984) ("We hold that the right of a patient, who is in an irreversibly comatose and essentially vegetative state, to refuse extraordinary life-sustaining measures, may be exercised either by his or her close family members or by a guardian of the person of the patient appointed by the court However, before either a close family member or legal guardian may exercise the patient's right, the primary treating physician must certify that the patient is in a permanent vegetative state and that there is no reasonable prospect that the patient will regain cognitive brain function and that his existence is being sustained only through the use of extraordinary life-sustaining measures. This certification should be concurred in by at least two other physicians with specialties relevant to the patient's condition.").

25. *Browning II*, 568 So. 2d 4, 13 (Fla. 1990); see also Normal L. Cantor, Quinlan, *Privacy and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 252 (1977) ("Any other view would permit obliteration of an incompetent's panoply of rights merely because the patient could no longer sense the violation of those rights.").

26. *In re Dubreuil*, 629 So. 2d 819, 820 (Fla. 1993).

27. *Rodriguez v. Pino*, 634 So. 2d 681, 685 (Fla. Dist. Ct. App. 1994) (citing *In re Dubreuil*, 629 So. 2d at 822) (overturning medical malpractice judgment against doctor who followed patient's wish to detach her respirator). See also Bruce J. Winick, *Advance Directive Instruments for Those with Mental Illness*, 51 U. MIAMI L. REV. 57, 58 (1996).

28. FLA. CONST. art. I, § 23.

29. See *Griswold v. Connecticut*, 381 U.S. 479, 483-84 (1965).

In theory, at least, Florida's robust constitutional right to refuse treatment solves the practical and ethical challenges of regulating living wills and end-of-life care. By placing decision-making power in patients' hands, the right limits state overreach. And by focusing on refusal of treatment, rather than affirmative acts, it attempts to foreclose application to assisted suicide and euthanasia. However, it raises a new problem—how do you determine the will of an unconscious person?

B. Browning's *Broad Construction of Intent*

A quick look at Mrs. Browning's living will indicates the degree to which an intent-oriented jurisprudence is primed for error. Mrs. Browning stated that she wished her life support to be removed in the event she had a "terminal condition," her death was "imminent," and there was no hope of recovery from this condition.³⁰

In response to the language of Mrs. Browning's will, one might ask what Mrs. Browning meant, precisely, by "recovery," "imminent," and "terminal." Certainly, Mrs. Browning's post-stroke condition did not neatly track with this language—she could, and did, survive for years on life support.³¹ This problem raises perhaps the most critical end-of-life question in a legal system that purports to value personal autonomy over other considerations. Specifically, what level of knowledge must a patient have when drafting a living will, or describing her preferences to friends and family members? It is one thing to say, as Mrs. Browning did, that one would wish life support to be removed in the event of a terminal condition presenting no hope of recovery. But it is much harder to anticipate that the miracle of modern medicine presents legions of methods of keeping a person biologically alive while failing to restore anything close to a decent quality of life, and that these medical interventions can create a nearly infinite realm of potentially tragic choices.³²

30. Browning II, 568 So. 2d 4, 8 (Fla. 1990).

31. *Id.*

32. In a perfect world, or at least one where all Americans had access to attorneys and doctors who could properly advise them of their legal and medical rights, questions such as these would scarcely ever be asked. Unfortunately, that is not our world. Most patients who receive end-of-life care know little to nothing of the care, or the scope of their right to refuse it. See e.g. Susan Adler Channick, *The Myth of Autonomy at the End-of-Life: Questioning the Paradigm of Rights*, 44 VILL. L. REV. 577, 592 (1999) ("Perhaps the most unexpected and puzzling finding regarding the efficacy of the autonomy paradigm in health decisions has come from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment ("SUPPORT"). SUPPORT, the largest piece of contemporary research on the end stage of dying in America, was a \$28 million project funded by the Robert Wood Johnson Foundation and co-directed by Joanne Lynn, M.D., now head of the Center to Improve Care of the Dying, and William A. Knaus, M.D., now chief of the department of health evaluative sciences at the University of Virginia School of Medicine. The purpose of the study was to discover what happened to patients and their families in the weeks and months following an acute episode that precipitated hospitalization for advanced illnesses. After

This complex interaction between a known patient preference and an unanticipated medical situation is exactly what sparked the controversy in *Browning*. Following Mrs. Browning's stroke, her eighty-year-old cousin, Doris Herbert, was appointed as Mrs. Browning's guardian.³³ Ms. Herbert, believing that Mrs. Browning's living will applied to her semi-conscious, dependent condition, petitioned a Florida trial court for permission to withdraw Mrs. Browning from life support.³⁴

The State of Florida opposed Ms. Herbert's petition. The State largely ignored the technical vagaries in Mrs. Browning's living will and instead argued that the removal of life support from a woman in a medically stable condition could form a troubling precedent.³⁵ The State persuaded the trial court, which promptly ordered that Mrs. Browning remain on life support.³⁶

The trial court in Mrs. Browning's case based its denial of Ms. Herbert's petition on the meaning of the word "terminal" as contained in Mrs. Browning's living will, and as defined in the Advance Directive Statute.³⁷ The statute at that time held that life support could not be removed from a patient unless that patient was medically determined to be terminally ill.³⁸ Yet, because Mrs. Browning could have lived in her unconscious, medically supported state for an indefinite period of time with artificial life support, the trial court reasoned that she failed to satisfy the Florida Advance Directive Statute's "terminal" requirement, and therefore, her living will could not be used to withdraw life support.³⁹

Mrs. Browning died in the nursing home after two and a half years on life support.⁴⁰ She was eighty-nine years old. Ms. Herbert's petition to remove life support, at the time of Mrs. Browning's death, was pending before Florida's Supreme Court.⁴¹ Ms. Herbert promised to pursue the appeal because a favorable appellate review "might help someone

observing the patients' treatment and medical decision-making, the study decided that patients received overly aggressive treatment without sufficient discussion beforehand to enable the patient to understand the consequences of such treatment and, presumably, to make informed choices.").

33. *Browning I*, 543 So. 2d 258, 261 (Fla. Dist. Ct. App. 1989) (noting that Ms. Herbert was Mrs. Browning's only living relative; both her only child and her son predeceased her).

34. *Florida Woman Dies Attached to a Tube; Legal Fight Goes On*, N.Y. TIMES (July 19, 1989), <http://www.nytimes.com/1989/07/19/us/florida-woman-dies-attached-to-a-tube-legal-fight-goes-on.html>.

35. *Id.*

36. *Id.*

37. *Browning I*, 543 So. 2d at 264.

38. *Id.*; see also FLA. STAT. § 765.04(1) (1987) (repealed 1992).

39. *Browning II*, 568 So. 2d at 9 ("Construing Florida's 'Life-Prolonging Procedure Act,' [Florida Statutes §§ 765.01-.15 (1987)], the trial court concluded that death was not imminent, and it denied the petition.").

40. *Florida Woman Dies Attached to a Tube*, *supra* note 34.

41. *Id.*

else.”⁴²

The Florida Supreme Court obliged, holding that the Florida Constitution provided a powerful right to refuse medical treatment, and that the hospital and trial court violated this right by disregarding Mrs. Browning’s living will.⁴³ Notably, both the Second District and the Florida Supreme Court soundly rejected the trial court’s focus on statutory technicalities—specifically, the meaning of the word “terminal” in the Advance Directive Statute, as drafted at the time of the case.⁴⁴ While the trial court had found the technical definition of this term to be outcome-determinative, Florida’s highest court indicated that the proper inquiry is whether the evidence of the patient’s wishes indicates a clear—if generalized—desire to refuse treatment.⁴⁵

The Florida Supreme Court’s decision in *Browning* illustrates that, in questions of patient autonomy, intent trumps technicalities. In essence, the court put the evidence of Mrs. Browning’s wish to refuse futile treatment far above the “terminal condition” requirement, or the exact language of Mrs. Browning’s living will. The Florida Supreme Court held that a patient who has articulated a general wish to withdraw from medical treatment, as Mrs. Browning clearly had, must have that wish respected, even if she has subsequently lost the physical capacity to orally articulate it.⁴⁶ Implicit in the court’s decision was the assumption that a broadly worded desire to withdraw from treatment in the event of a “terminal” illness would also apply to a tragic condition of severe and permanent incapacitation.⁴⁷

In other words, *Browning* stands for two important propositions in addition to its well-known holding that incapacitated Floridians retain their right to refuse treatment.⁴⁸ First, *Browning* indicates that technical statutory terms describing a particular clinical prerequisite for the removal of life support are not a critical component of any constitutional inquiry into patient intent.⁴⁹ If the patient suffers from a dire and hopeless condition, and if the patient had clearly stated her intention to refuse

42. *Id.*

43. *Browning II*, 568 So. 2d at 9.

44. See *Browning I*, 543 So. 2d at 287 (“Distinguishing between serious illnesses, life-threatening conditions, and terminal illnesses is frequently difficult for physicians and nearly impossible for the legal community.”); *Browning II*, 568 So. 2d at 9 (“We agree with the district court that chapter 765 of the Florida Statutes (1987) is not applicable to Mrs. Browning’s situation.”).

45. See *Browning II*, 568 So. 2d at 10.

46. *Id.* at 9.

47. *Id.* at 10 (“A competent individual has the right to refuse medical treatment regardless of his or her medical condition.”).

48. *Id.* at 12 (“Thus, our cases have recognized no basis for drawing a constitutional line between the protections afforded to competent persons and incompetent persons.”).

49. *Id.*

treatment in such a condition, the patient retains a constitutional right to do so. In implying this conclusion, the *Browning* court sidestepped the fact that Mrs. Browning's condition probably did not meet a plain reading of the Advance Directive Statute's definition of "terminal."⁵⁰

And second, *Browning* teaches a similar lesson about living wills. If the intent of the patient to refuse futile medical care at the end of her life is clearly stated, then *Browning* requires no precise parsing of the terms in her living will.⁵¹ Under *Browning*, an incapacitated patient did not have to foresee *any* possible medical situation. Rather, if her wishes can be shown to reasonably apply to the situation at hand, a proxy or guardian may exercise her right to refuse treatment on her behalf.⁵²

Browning's broad approach to the removal of life support is controversial. For one, as described above, *Browning* and its progeny go a far sight beyond the United States Supreme Court's pronouncements on the matter. The decision also incensed social conservatives. The Florida Catholic Conference excoriated *Browning* as exhibiting "a philosophy of excessive individualism that ignores any social action or societal role in the protection of unborn children, teenagers, the elderly, senile, or the infirm There is almost an assumption that certain patients are better off dead than alive" ⁵³

III. THE ADVANCE DIRECTIVE STATUTE

Florida's Advance Directive Statute represents a hasty attempt to reign in *Browning's* broad, functional approach to removing life support. Social conservatives were concerned, perhaps justifiably, that a loose application of the case could toe the line of assisted suicide and euthanasia. But the compromise statute that resulted from this concern serves as a nearly archetypical example of hard cases making bad law. The Advance Directive Statute in effect today has essentially eviscerated

50. An argument could also be made that the *Browning* court implicitly rewrote the problematic statutory definition of "terminal" to avoid an inequitable result. Under the statute (as well as under Mrs. Browning's own living will), a "terminal" condition was one that made death "imminent." Yet Mrs. Browning's death was not imminent—as discussed above, she could, and did, survive for years on life support. Nevertheless, the *Browning* court concluded that, because medical testimony showed that Mrs. Browning could not recover, "clear and convincing evidence existed to support a finding that Mrs. Browning suffered from a terminal condition." *Browning II*, 568 So. 2d at 17. While the *Browning* court's disregard of the statutory immanency requirement could be criticized as a sort of "soft" judicial activism, it nevertheless illustrates the mess that the "terminal condition" test poses for courts, and the interpretive gymnastics required to navigate it without violating patients' privacy rights.

51. *Browning II*, 568 So. 2d at 15.

52. *Id.*

53. Commentary, *In Re: Guardianship of Estelle M. Browning, What Hath the Supreme Court Wrought?*, 10 FLA. CATHOLIC CONFERENCE NO. 3 (1990) (construing *Browning II*, 568 So. 2d 4 (Fla. 1990)), available at <http://www.flaccb.org/Commentaries/Comm1290.htm>.

Browning's constitutional holding, and yet fails to adequately protect vulnerable patients.

A. *The Evolution of an Unconstitutional Law*

In 1997, the Florida legislature and the Florida State University Pepper Institute on Aging convened the Panel of the Study of End of Life Care, a group of twenty health care professionals, elected officials, scholars, and clergy, to recommend changes to the Advance Directive Statute.⁵⁴ The Panel conducted a series of hearings and public discussions across the state to gauge public sentiment on end-of-life care, and panelists were disturbed by what they learned.⁵⁵ Floridians regularly reported that hospitals and doctors refused to remove life support from patients who were dying and in pain, and who had clear living wills. *Browning's* broad functional approach to the right to refuse treatment, it seemed, had failed to take hold at the ground level.

The Panel traced hospitals' refusal to implement living wills to the Advance Directive Statute.⁵⁶ The statute, as it existed in 1997, still contained the vague "terminal condition" test that led the trial court to void Mrs. *Browning's* living will, as discussed above.⁵⁷ That test required that a patient be in a "terminal condition," as determined by two doctors, before the patient's living will would be honored.⁵⁸ A "terminal condition," as defined in the statute at the time, was a condition that would cause death if left untreated.⁵⁹ This definition was incomprehensible to anyone who took the time to think about it.⁶⁰

The 1997 definition of terminal condition was problematic for being both over- and under-inclusive.⁶¹ On one hand, it is hard, in many cases, to say that a person with a terminal disease will certainly not live with or without treatment. So, cautious doctors were more likely to over-treat patients than to remove life support in accordance with a valid liv-

54. Cava, *supra* note 19 at 8–9.

55. Bebe Bahnsen, *Hearing Focus is Care at the End: The Panel's Goal is to Ensure that Floridians Have Access to Adequate Pain Management*, Sarasota Herald-Tribune, Nov. 8, 1998 at 1B, available at NEWSBANK, No. 9811080235 ("Brooks said the panel has heard testimony from people whose relatives' end-of-life wishes were ignored in some care settings even though they had completed living wills.").

56. Diane C. Lade, *Panel Discusses Giving Patients More Control Over Life's End*, SUN SENTINEL, Feb. 8, 1999 at 1B ("[T]he doctors refused to honor [advance directives] because Florida law states that they go into effect only when a patient is declared terminal.").

57. Goodman, *Persistent Legislative State*, *supra* note 19, at 34.

58. Goodman, *National Living Wills and Local Politics*, *supra* note 19.

59. *Id.*

60. *Id.*

61. See also Goodman, *Commentary*, *supra* note 19 ("This definition has served mainly to confuse everyone who has tried to invoke it or obey the law.").

ing will.⁶² On the other hand, a literal interpretation of “terminal condition” would have legitimized absurd results. Thirst, for example, would lead to death if left untreated. That does not, in any sensible world, make thirst a “terminal condition” justifying the removal of life support.

Bob Brooks, an immune disease specialist and former Republican state representative, led the panel in an effort to alter the “surreal progression” of end-of-life care, “in which rigid health care rules or high-tech machines seize control of those important final hours.”⁶³ The Panel met with heavy press coverage and received extensive input from the public.⁶⁴ Floridians shared heartbreaking stories of loved ones forced to continue a painful existence and accept invasive, often futile surgical interventions in the face of explicit “Do Not Resuscitate” orders and living wills.⁶⁵ As Brooks noted, “the most common issue people [were] bringing up is with people not having their desires fulfilled as they approach the end of their life,” even in the presence of explicit living wills and hopeless conditions.⁶⁶

The panel concluded its study with a recommendation, passed by a nineteen-to-one vote, that the legislature delete the “terminal condition” test from the Advance Directive Statute and reaffirm *Browning’s* focus on patient intent, rather than on vague clinical definitions.⁶⁷ The Florida Board of Medicine and a considerable majority of polled doctors and lawyers supported the panel’s majority.⁶⁸ Five bipartisan committees, in both the Florida House and Senate, voted unanimously to accept the

62. Bahnsen, *supra* note 55 (summarizing numerous stories in which individuals recounted how their family members had been forced to accept unwanted life-prolonging treatment).

63. Bob Brooks, Editorial, *Speak on End-of-Life Care Issues*, SUN SENTINEL (Fla.), Oct. 26, 1998 at 9A, available at NEWSBANK, No. 9810230613.

64. Bahnsen, *supra* note 55.

65. *Id.* See also Brooks, *supra* note 63; Lindsay Peterson, *Bill Reinforces Patients’ Right to Living Wills*, THE TAMPA TRIBUNE, Apr. 19, 1999 at A1, available at NEWSBANK, No. 041999012; Goodman, *Persistent Legislative State*, *supra* note 19 at 34 (“Consequently, patients who executed living wills expecting they would be spared unwanted resuscitation, were ventilated, fed, and watered because their doctors reckoned they could thereby keep them alive, which meant they were not terminally ill. In case after case, family members protested that a loved one never wanted such treatment, only to be shown a signed living will in which the loved one seemed to be agreeing to a requirement that they meet the terminal condition test.”); Lade, *supra* note 56 (The panel conducted eight hearings, “listening to Floridians recite heartbreaking tales and voice their fears about slow, humiliating deaths. Their testimony persuaded panelists that Florida needs better ways to treat its dying.”) In one particularly poignant story, an elderly man executed an explicit living will and repeatedly told his wife he did not wish to be kept alive artificially, in the event he was incapacitated. The man suffered a massive stroke, and was kept alive, against his wishes and his wife’s requests, for weeks by an artificial respirator and feeding tube. When the man woke from his coma, he was barely functional and unable to recognize his wife of more than 50 years. He died in a nursing home.

66. Bahnsen, *supra* note 55.

67. Cava, *supra* note 19, at 8; Goodman, *Persistent Legislative State*, *supra* note 19, at 36.

68. Lade, *supra* note 56.

recommendation.⁶⁹ And that was as far as it went.

The panel's lone dissenting vote, Jim Towey,⁷⁰ attacked the majority, echoing the earlier critiques of *Browning*. Towey claimed that the Panel's recommendation "would make Florida one of the most liberal states when it comes to dying."⁷¹ "What scares me," Towey said, "is that there isn't any safety net out there for people who are uninsured or making decisions when depression is at work."⁷²

Towey's minority position ultimately carried the day. According to a member of the panel, Towey persuaded then-Governor Jeb Bush to threaten to veto any legislation that made it "easier" for people to die.⁷³ Shortly before the Legislature voted on the new Advance Directive Statute, the "terminal condition" requirement was quietly reinserted in to the bill.⁷⁴

The Legislature did not stop, however, at ignoring the panel's recommendation. Not only did the Legislature retain the "terminal condition" language,⁷⁵ it also added two new and similarly vexing terms: "persistent vegetative state"⁷⁶ and "end-stage condition."⁷⁷ There is no recorded legislative rationale for making these changes.⁷⁸ Apparently the "end-stage condition" and "persistent vegetative state" categories were

69. Goodman, *Persistent Legislative State*, *supra* note 19, at 36.

70. Towey, currently president of Ave Maria University, has served as legal counsel to Mother Teresa and director of President George W. Bush's Office of Faith-Based and Community Initiatives. See *President's Page: H. James Towey*, AVE MARIA UNIV., <http://www.avemaria.edu/AboutAveMaria/PresidentsPage.aspx> (last visited Jan. 1, 2012).

71. Lade, *supra* note 56.

72. *Id.*; See also Alison Cossetti, *End-of-Life Care in Florida: Should the Law Follow the Lobbyists or the People's Wishes?*, 14 ST. THOMAS L. REV. 13, 18 (2001) (noting that Towey and the Florida Catholic Conference were concerned that removing the terminal condition requirement "might subtly encourage the health care industry to withhold expensive care from the poor and other vulnerable people who are [not] clearly dying.") (alteration in original) (quoting Peterson, *supra* note 65).

73. Telephone interview with Kenneth Goodman, Dir., Univ. of Miami Bioethics Program (Dec. 2011).

74. Lucy Morgan, *End-of-Life Measure Advances*, ST. PETERSBURG TIMES, Apr. 8, 1999, at B6.

75. FLA. STAT. § 765.101(17) (2012) ("Terminal condition' means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.").

76. FLA. STAT. § 765.101(12) (2012) ("Persistent vegetative state' means a permanent and irreversible condition of unconsciousness in which there is: (a) The absence of voluntary action or cognitive behavior of any kind. (b) An inability to communicate or interact purposefully with the environment.").

77. FLA. STAT. § 765.101(4) (2012) ("End-stage condition' means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.").

78. *Legislature Clarifies, Corrects Aspects of State's Advance Directive Statute*, FLA. BIOETHICS NETWORK, Summer 2011, at 1, 4 [hereinafter *Legislature Clarifies*] (noting that the

the product of a compromise intended to garner conservative support for the bill.⁷⁹

The compromise worked. The Florida Catholic Conference immediately reversed its opposition to the Advance Directive Statute and announced its support for the new version.⁸⁰ The Legislature jammed the changes into an omnibus bill in a flurry of end-of-session activity.⁸¹ Governor Jeb Bush signed the bill into law on June 11, 1999.⁸² It is still the law today. The only notable change has been a slight tweak to the definition of “end-stage condition” in 2001.⁸³

B. *The Mechanics of the Advance Directive Statute*

The Florida Legislature’s 1999 revisions to the Advance Directive Statute did not alleviate the problems addressed in *Browning* and further identified by the Panel of the Study of End of Life Care. If anything, the addition of the “end-stage condition” and “persistent vegetative state” categories made the Statute more unwieldy than it had been when it contained only the “terminal condition” requirement. Now, hospitals have three, rather than one, confusing and vague clinical definitions to contend with when considering a patient’s living will. The effects of these amendments, both practically and constitutionally speaking, are troubling.

A complete understanding of why the 1999 categories contradict *Browning* first requires an understanding of how the Advance Directive Statute was intended to work, absent the end-stage/ terminal/ persistent vegetative state restrictions. Apart from these restrictions, the statute more or less codifies *Browning* and its progeny, with a few added procedural protections. The statute begins by noting that “[t]he Legislature finds that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment.”⁸⁴

The Florida Supreme Court’s decisions recognize that this right—

legislature added the three tests, “which many patients, families and health professionals have found onerous,” for purely “political considerations.”)

79. Cossetti, *supra* note 72, at 19 (“The lobbyists and the senators might believe that this is a sufficient compromise, but it still does not give people the option to refuse treatment in the early stages of a disease that they know will only get worse. In addition, the classifications are still subject to interpretation, despite being defined in the Senate Bill.”); Cava, *supra* note 19, at 9 (“Appreciating exactly what these words mean requires a degree of medical/legal sophistication. The statute sets out to draw some parameters, but it is obvious that the devil is in the details.”).

80. Morgan, *supra* note 74.

81. Goodman, *Commentary*, *supra* note 19, at 6.

82. *Id.*

83. *Legislature Clarifies*, *supra* note 78, at 1.

84. FLA. STAT. § 765.102(1) (2012).

like all constitutional rights⁸⁵—is not unfettered. Two constitutionally acceptable restrictions on the right to refuse medical care emerge from the court's end-of-life jurisprudence. The first is evidentiary. Most people do not execute living wills, and the statute—as *Browning* directs—demands clear and convincing evidence of all patients' wishes for their own end-of-life care. The second restriction involves a balancing of certain state interests against an individual's right to refuse treatment.

1. PROOF-BASED RESTRICTIONS ON THE RIGHT TO REFUSE TREATMENT

Under *Perlmutter* and *Dubreuil*, competent and conscious patients have a nearly ironclad right to refuse treatment. And under *Browning* and *Bludworth*, this right extends to unconscious (aka “incompetent”) patients who expressed their desires at a time when they were competent to do so.⁸⁶ Yet, it can be damnably difficult to divine the wishes of an incompetent patient—even one who drafted a living will. As discussed in detail above, even Mrs. Browning's living will was rather vague in application. So what should courts and hospitals do, when a patient's life could hinge on the interpretation of broad, unspecific terminology? What if a patient did not leave a living will, but instead had a long conversation with a close friend regarding his final wishes? What if a patient, rather than having a long conversation, flippantly mentioned, after watch *Awakenings* on cable, that she would rather die than live in a coma?

In other words, *Browning*'s holding creates not only an ethical challenge, but an evidentiary one as well. How do we know which sophisticated and complex medical interventions that a person with no medical training would have chosen to accept or reject in a given situation?

In *Browning*, the Florida Supreme Court indicated that the Florida Constitution provides incompetent individuals the right to refuse treatment, even if their expressed wishes were broad, vague, or inarticulate. The court held Mrs. Browning's living will valid, even though the document addressed a “terminal” condition and “imminent” death, because

85. See, e.g., Justice David H. Souter, *Harvard University's 359th Commencement Address*, 124 HARV. L. REV. 429, 433–34 (2010) (“We want order and security, and we want liberty. And we want not only liberty but equality as well. These paired desires of ours can clash, and when they do a court is forced to choose between them, between one constitutional good and another one. The court has to decide which of our approved desires has the better claim, right here, right now, and a court has to do more than read fairly when it makes this kind of choice.”).

86. See e.g. *John F. Kennedy Mem'l Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984) (“We agree with the district court that terminally ill incompetent persons being sustained only through use of extraordinary artificial means have the same right to refuse to be held on the threshold of death as terminally ill competent persons.”).

Mrs. Browning had indicated a broad desire to withdraw from treatment in any situation of incapacitation with no hope of recovery. Similarly, the Advance Directive Statute also contains mechanisms that focus the attention of judges, attorneys, and healthcare providers on evidence of patient intent.⁸⁷

Specifically, the statute, like *Browning*, places the burden of proof on the party attempting to remove life support, and requires—also like *Browning*—clear and convincing evidence. The statute explicitly guarantees that a patient who has executed a living will is entitled to “a rebuttable presumption of clear and convincing evidence” of intent to refuse treatment.⁸⁸ A physician treating a patient with an explicit living will “may proceed as directed by the principal in the living will,”⁸⁹ without fear of criminal or civil liability.⁹⁰ The only proof-based restriction on the implementation of a living will is that a physician’s decision to remove life support can be challenged by a family member, doctor, or other “interested person,” who may present evidence that the living will is “ambiguous, or the patient has changed his or her mind after execution of the advance directive.”⁹¹

The Statute divides patients without a living will into two broad categories: those who have appointed a health care “surrogate,” and those who have not.⁹² Put simply, patients with “surrogates”—individuals specially appointed to make choices on the patient’s behalf⁹³—are second best to patients with living wills, and patients without either are the third best. Surrogates are legally authorized to make health care decisions on behalf of an incompetent patient, including the decision to remove life support, so long as the patient “does not have a reasonable medical probability of recovery.”⁹⁴

The statute gives the least evidentiary deference to a patient who did not execute a living will or delegate the authority to make health-care-related decisions to someone else.⁹⁵ This is the most significant cat-

87. As discussed in greater detail below, the terminal/ end-stage/ persistent vegetative state categories ultimately overshadow this initial statutory focus on intent.

88. FLA. STAT. § 765.302(3) (2012).

89. FLA. STAT. § 765.304(1) (2012).

90. FLA. STAT. § 765.109(1) (2012).

91. FLA. STAT. § 765.105(2) (2012).

92. See Shepherd, *supra* note 17, at 364 (“Surrogate decision-making is generally considered second best to the living will.”).

93. See FLA. STAT. § 765.203 for a sample surrogate designation form. FLA. STAT. § 765.202 governs the procedure by which a surrogate is appointed.

94. FLA. STAT. § 765.305(2)(a) (2012).

95. In fact, the end-stage/ terminal/ persistent vegetative state categories only apply, under the plain language of the statute, to those patients with a surrogate, but without a living will, and not to (1) patients with living wills, or (2) patients without living wills or surrogates (i.e., those with proxies). Fla. Stat. § 765.305(b)(2) (2012). Like the portion of the statute dealing with pregnant

egory in the statute, as more than eighty percent of people do not have a living will or a designated healthcare decision-maker.⁹⁶ Patients who fall into this category have a health care “proxy” appointed for them by statute, with preference given to closer family relations.⁹⁷ The proxy may make health care decisions for the patient,⁹⁸ including the decision to withhold life-sustaining treatments, but must prove by “clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent”⁹⁹ This requirement can be difficult to meet, particularly in cases involving young and apparently healthy people who never thought to explicitly discuss their end-of-life care preferences with friends or family members.

Still, there are sound policy reasons to statutorily restrict the freedom of proxies to make healthcare-related decisions for their family members. There is no ironclad guarantee that a family member will know what a patient would choose in any given situation.¹⁰⁰ In fact, one study showed that proxies and patients, faced with the same set of hypothetical facts, make different decisions on whether to forego or continue health care treatments as much as thirty percent of the time.¹⁰¹

Furthermore, evidence of the desires of a patient without a living will is often spotty, taking the form of hearsay, “don’t let me live like that” statements. Such statements should be viewed with extreme skepticism when brought to court as evidence supporting a petition to withdraw treatment. For one, these statements would be inadmissible hearsay (absent an exception) in a normal trial. Moreover, they do not indicate the kind of careful consideration of a person who took the time to draft a living will or appoint a healthcare surrogate. Finally, such statements are apt to be even less specific than the conditional language in typical living wills. So, a high burden of proof on an incapacitated patient’s proxy is a useful and necessary safeguard against the removal of medical

patients, this provision appears to contain a latent drafting error. Taking the statute as a whole, the end-stage/ terminal/ persistent vegetative state restrictions are meant to apply to patients with living wills as well as patients without living wills or surrogates. Certainly, it would be illogical to apply a bright-line restriction to patients with greater evidence of intent (those with surrogates), but not to patients with little to no evidence of intent (those with proxies).

96. Shepherd, *supra* note 17, at 374 (“This number has remained relatively constant despite efforts to educate the public about living wills, laws requiring hospitals to inform patients about the availability of living wills, and programs to increase the facility of doctors and other health care providers in talking to patients about living wills.”).

97. FLA. STAT. § 765.401 (2012).

98. § 765.401(2).

99. § 765.401(3).

100. See Winick, *supra* note 27, at 75.

101. Jan Hare, Clara Pratt & Carrie Nelson, *Agreement Between Patients and Their Self-Selected Surrogates on Difficult Medical Decisions*, 152 ARCHIVES INTERNAL MED. 1049, 1051–53 (1992).

care.¹⁰²

2. POLICY-BASED RESTRICTIONS ON THE RIGHT TO REFUSE TREATMENT

The Advance Directive Statute's second inhibition is rooted in *Browning's* recognition that some state interests can, in limited circumstances, trump individual autonomy.¹⁰³ The Florida Supreme Court has identified four compelling state interests that can, on a case-by-case basis, counterbalance a patient's wish to refuse medical treatment.¹⁰⁴ Those are (1) the preservation of life; (2) the protection of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession.¹⁰⁵ Interests associated with euthanasia, such as expense or convenience, are not to be considered under any circumstances.¹⁰⁶

The Advance Directive Statute incorporates these restrictions in several ways. For example, the statute provides that, absent a court order, a surrogate or proxy cannot provide consent for experimental treatments, electroshock therapy, psychosurgery, or sterilization.¹⁰⁷ And it also controversially restricts the removal of life support from pregnant women.¹⁰⁸ Under the statute, an unconscious or otherwise incompetent woman with an explicit living will and a legally designated health care surrogate may not exercise her right to refuse medical treatment before

102. In his dissent to the majority opinion in *Cruzan*, Justice Brennan pointed out that Missouri's presumption in favor of treating patients without living wills presented an asymmetric burden. That is, while the proxy bears the burden of proving a wish to refuse treatment, no evidence whatsoever is required to maintain treatment, or, in Justice Brennan's words, to make the patient a "passive prisoner of medical technology." *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 302, 315-17 (1990). Justice Brennan's approach is worth noting here because Florida, like Missouri, requires evidence of an intent to refuse treatment, but no evidence of any desire to accept treatment. Florida's judges and legislators, like most lawmakers nationwide, apparently disagree with Brennan's approach, which largely ignores the practical pressures, such as economic cost and emotional strain, that might lead proxies or families to reach decisions that may not be in an incompetent patient's best interests.

103. *Browning II*, 568 So. 2d 4, 13-14 (Fla. 1990) ("The state has a duty to assure that a person's wishes regarding medical treatment are respected. That obligation serves to protect the rights of the individual from intrusion by the state unless the state has a compelling interest great enough to override this constitutional right. The means to carry out any such compelling state interest must be narrowly tailored in the least intrusive manner possible to safeguard the rights of the individual.").

104. *Singletary v. Costello*, 665 So. 2d 1099, 1105 (Fla. Dist. Ct. App. 1996) (citing *Browning*, 568 So. 2d at 14).

105. *Id.*

106. *Browning II*, 568 So. 2d at 13.

107. FLA. STAT. § 765.113 (2012).

108. FLA. STAT. § 765.113(2) (2012).

her fetus is “viable,”¹⁰⁹ that is, deliverable,¹¹⁰ absent a court order.¹¹¹ Most states have similar restrictions.¹¹²

These restrictions, whether you agree with them or not, are nevertheless on the spectrum of state interests that can, in limited circumstances, trump an individual’s right to refuse medical care. The bans on fringe therapies such as psychosurgery and sterilization protect the integrity of the medical profession, and the pregnancy-related restrictions protect the life of the unborn. This makes them a stripe of a different color than the terminal/ end-stage/ persistent vegetative state categories, as demonstrated in further detail below.

C. *Off the Rails: The Statute Abandons Its Constitutional Framework*

So far, so good. The Advance Directive Statute’s evidentiary and policy-based restrictions—while their wisdom can be debated—are at least grounded in a coherent body of constitutional law. The next restriction is not. After articulating the *Browning* proof- and policy-based restrictions on the right to refuse medical treatment, the Advance Directive Statute presents a third condition: after a patient’s wishes are determined to a reasonable certainty, and after all policy-based restrictions are disposed of, hospitals must then determine whether a patient (1) has a terminal condition, (2) has an end-stage condition, or (3) is in a persistent vegetative state. If two doctors cannot agree that a patient falls within one of these ill-defined categories, the patient’s life support may not be removed, regardless of the patient’s living will or actual condition.

The terminal/ end-stage/ persistent vegetative state categories do not fit within the Florida Supreme Court’s constitutional framework. The court allows the right to refuse medical care to be counterbalanced, on a case-by-case basis, by state policy interests or a lack of clear evi-

109. FLA. STAT. § 765.113(2) (2012).

110. See *Roe v. Wade*, 410 U.S. 113, 163 (1973) (defining “viability” as the point at which the fetus has the capacity for “meaningful life” on its own).

111. This provision actually states that a proxy or surrogate may not consent to “[w]ithholding or withdrawing life-prolonging procedures from a pregnant patient prior to viability.” FLA. STAT. § 765.113(2) (2012). Taken literally, this provision means that doctors can remove a pregnant woman’s life support once the fetus is viable, i.e., deliverable, regardless of whether the doctors actually deliver the unborn child. Clearly, the statute’s drafters intended for the child to be delivered first, and *then* for life support to be removed. But this intention—like so many things in the statute—is not explicitly drafted into the statute.

112. See e.g. Craig K. Van Ess, *Living Wills and Alternatives to Living Wills: A Proposal—The Supreme Trust*, 26 Val. U. L. Rev. 2 at 569 (Spring 1992) (“Under the typical living will statute, a competent, *non-pregnant* adult may” execute a living will.) (emphasis added).

dence of the patient's wishes. Yet the Statute's three categories do not appear to fit within either exception.

The terminal/ end-stage/ persistent vegetative state categories are clearly not proof-based, as they bear no relationship to a patient's final wishes. Imagine, for example, the rare patient who follows the advice of both lawyers and academics, and executes an explicit living will. The patient even goes so far as to learn some basic facts about end-of-life care and to explicitly describe the situations in which she would prefer to withdraw life support. This patient is then involved in a car accident, which leaves her tragically brain-dead and incapable of breathing or swallowing on her own. She has no chance of recovery, and her family members agree that her wish, in this situation, would be to remove life support and pass away naturally.

In this case, there is no controversy over the patient's wishes. Her desire is clear, and her condition is hopeless and irreversible. She is kept alive only by a feeding tube and respirator. Yet hospital lawyers could—and indeed, should, under the Advance Directive Statute—advise this patient's doctors to disregard her living will. The patient does not clearly have a terminal condition, because she can be kept alive indefinitely by artificial support. The patient does not have an end-stage condition, because her health remains stable as long as she is attached to a respirator and feeding tube. Finally, she is in a coma, rather than a persistent vegetative state.¹¹³ In this hypothetical situation, the end-stage/ terminal/ persistent vegetative state restrictions block the exercise of a fundamental right, regardless of how well-articulated, clearly documented, or appropriate that exercise is.

Similarly, the terminal/ end-stage/ persistent vegetative state categories do not readily fit within the Florida Supreme Court's framework for policy-based restrictions on the right to refuse medical care. In Florida, an individual's right to refuse medical treatment can be overcome only by a "compelling" state interest.¹¹⁴ Moreover, the means used to enforce that state interest must be "narrowly tailored in the least intrusive manner possible."¹¹⁵ The terminal/ end-stage/ persistent vegetative state categories upset this balance, because they can counteract a clearly articulated desire to refuse treatment in situations with no easily identifiable state interest. For example, in the hypothetical posed above, the patient is not pregnant. She is not being subjected to marginal therapies.

113. The distinction between "coma" and "persistent vegetative state" is not entirely clear to this author, but is discussed in slightly greater detail below.

114. *Browning II*, 568 So. 2d at 13–14.

115. *Singletary v. Costello*, 665 So. 2d 1099, 1105 (Fla. Dist. Ct. App. 1996).

She is not suicidal. Yet she is forced to remain brain-dead and on life support indefinitely.

The Advance Directive Statute's restriction on the right of pregnant women to refuse medical care is instructive in how it differs from these categories. Academic commentators have attacked Florida's restrictions on the rights of pregnant women to refuse medical care as reducing women to the status of "chattel" or an "incubator or reproductive vessel" for the state.¹¹⁶ These polemics hinge on the weight given to state interests and a particular theoretical approach to fetal life. The commentators argue that the woman's right to refuse medical treatment should outweigh the state's interest in preserving the life of the unborn.

Nevertheless, if you view fetal life as human life, then there is a state interest in its preservation.¹¹⁷ Additionally, there's an evidentiary issue lurking in the background of this provision, as few women would probably anticipate, in living wills or even casual conversation, the possibility of being pregnant and incapacitated. Reasonable people can disagree about how much weight should be given to these considerations, but the fact of a state interest in the preservation of human life and informed choices remains. Moreover, the Florida legislature has determined that the state's interest in fetal life temporarily outweighs the mother's interest in refusing medical care.

There is, however, no similar balancing of rights and policy informing the end-stage/ terminal/ persistent vegetative state categories.¹¹⁸ The statutory restrictions on the removal of life support from pregnant women reflect a coherent policy judgment that fetal life is generally more important than an incapacitated woman's right to refuse treatment. Moreover, the pregnancy restriction is limited in scope to the point at which the fetus is capable of meaningful life beyond the womb. Yet the three statutory restrictions, on the other hand, are subject to no weighing or balancing whatsoever. They form a bright-line, insurmountable obsta-

116. See, e.g. James M. Jordan III, *Incubating for the State: The Precarious Autonomy of Persistently Vegetative and Brain-Dead Pregnant Women*, 22 GA. L. REV. 1103, 1112 (1988) ("legislatures and courts may treat a woman as chattel and disregard her privacy rights once she becomes vegetative or brain-dead"); Timothy J. Burch, *Incubator or Individual?: The Legal and Policy Deficiencies of Pregnancy Clauses in Living Will and Advance Health Care Directive Statutes*, 54 Md. L. Rev. 528, 550 (1995) ("Simply allowing the state at the point of fetal viability to dictate what shall be done with an incompetent pregnant woman's body is violative of basic societal, moral, and philosophical beliefs and would equate an incompetent pregnant woman with an incubator or reproductive vessel.").

117. See *Singletary*, 665 So. 2d at 1105 ("Generally, the state interest in the preservation of life is considered the most significant.") (citing *Browning II*, 568 So. 2d at 14).

118. See Cava, *supra* note 19, at 8 ("Curiously, however, who effectuates the patient's desires is not nearly as complicated as when such desires become effective. Deciding when to 'provide, withhold, or withdraw life-prolonging procedures' in accordance with the advance directive is fraught with legal and ethical conundrums.").

cle to refusing medical care in any situation in which doctors and lawyers disagree about what category a patient might fit into.

IV. TERRI SCHIAVO: A CASE STUDY IN THE TRAGIC CONSEQUENCES OF BAD DRAFTING

The sad case of Terri Schiavo is well-known, but its complex interaction with the mechanisms of the Advance Directive Statute has largely been ignored. Yet the Schiavo case makes for the ultimate case study in the deep constitutional and practical flaws of the statute. Florida's Advance Directive Statute was the battleground on which Michael Schiavo's controversial petition to remove his wife's life support was fought. Yet, the statute did not work as intended. It did not mandate a searching inquiry into Terri's end-of-life wishes or best interests. Instead, it focused the courts' attention on one criterion that should have been tangential—whether Terri was in a persistent vegetative state.

Terri Schiavo was an apparently healthy 26-year-old woman when she had a heart attack and fell into a coma. Like most Americans, Terri had no living will or designated healthcare decision-maker.¹¹⁹ As mandated in the Advance Directive Statute, her husband stepped in as her proxy.¹²⁰ Michael Schiavo's first act was to sue Terri's obstetrician, from whom he won a million-dollar malpractice judgment.¹²¹ Most of that money was held for Terri's medical treatment.¹²²

The *Schiavo* controversy familiar to the general public began when Michael, as Terri's proxy, initiated proceedings to take his wife off life support.¹²³ At that point, Terri had been bedridden for seven years. Her heart attack had cut off oxygen flow to her brain for long enough to cause irreparable damage to her cerebral cortex, the portion of the brain

119. See *Recent Developments—Health Care Law—Treatment—Privacy Rights—Due Process—Withdrawal of Life Support—The Theresa Schiavo Decisions*, 33 FLA. ST. U. L. REV. 356, 362 (2005) [hereinafter *Recent Developments*] (citing *Schindler v. Schiavo ex rel. Schiavo (In re Guardianship of Schiavo)*, 780 So. 2d 176, 178 (Fla. Dist. Ct. App. 2001) [hereinafter *Schiavo I*]); Leslie Pickering Francis & Anita Silvers, *(Mis)framing Schiavo as Discrimination Against Persons with Disabilities*, 61 U. MIAMI L. REV. 789, 810–11 (2007) (“Part of what made the Schiavo litigation difficult from the beginning was the fact that Terri Schiavo had not executed any of the instruments available under Florida law to designate a preferred decision-maker or to direct her management—medical or otherwise—in case of incapacity. This was not surprising because Terri Schiavo was a young adult who was happily married and surrounded by a loving family. *Schiavo* thus involved issues about guardianship and proxy decision-making, but did not include the involvement of a designated surrogate.”).

120. *Recent Developments*, *supra* note 119, at 358.

121. *Schiavo I*, 780 So. 2d at 178.

122. *Id.*

123. See O. Carter Snead, *Dynamic Complementarity: Terri's Law and Separation of Powers Principles in the End-of-Life Context*, 57 FLA. L. REV. 53, 59 (2005).

responsible for conscious thought.¹²⁴ By mid-1996, CAT scans showed that nearly all of Terri's cerebral cortex had withered and been replaced with fluid.¹²⁵

Still, Terri was not in a coma. She could not swallow on her own, but she could breathe without the aid of a respirator. Moreover, she at least retained the appearance of a capacity to interact with her environment. Widely viewed YouTube videos show Terri gasping, and apparently laughing, as her father speaks to her in a gentle voice.¹²⁶ She was, in other words, in a gray area of personal awareness and consciousness known as a "persistent vegetative state."

A. *The Dangers of the Advance Directive Statute's Vague Clinical Categories*

"Persistent vegetative state" is possibly an even more dubious and vague designation than terminal condition or end-stage condition. A persistent vegetative state, according to the statute, is a condition of "unconsciousness in which there is (a) [t]he absence of voluntary action or cognitive behavior of any kind [and] (b) [a]n inability to communicate or interact purposefully with the environment."¹²⁷ Though the line between the two can be difficult to identify for those without medical training, a patient in a persistent vegetative state is not in a coma.¹²⁸

A persistent vegetative state is a nuanced and technical medical designation whose brief definition in the Advance Directive Statute belies its complexity as a medical concept. A persistent vegetative state diagnosis is so complex that the American Academy of Neurology developed a lengthy, densely researched definition for neurologists.¹²⁹ According to the AAN, persistently vegetative patients may be in the end stage of a degenerative neurological disease, such as Alzheimer's, or they may be recovering from a traumatic incident.¹³⁰ The condition is difficult to diagnose. A patient exhibiting even a minor ability to track objects with his or her eyes is not in a persistent vegetative state, according to the AAN, and could be experiencing some self-awareness and

124. *Recent Developments*, *supra* note 119, at 358.

125. *Id.*

126. GordanWayneWatts, *Terri Schiavo footage right B4 her death*. . . , YouTube (Sept. 16, 2011), <http://www.youtube.com/watch?v=P7fulbiC7Co>.

127. FLA. STAT. § 765.101(12) (2012).

128. Definition of Coma, MAYO CLINIC (Oct. 12, 2012), <http://www.mayoclinic.com/health/coma/DS00724> (A "coma" is "a state of prolonged unconsciousness").

129. See Special Article, *Medical Aspects of the Persistent Vegetative State* (pt. 1), 330 *NEW ENG. J. MED.* 1499 (1994), available at <http://www.nejm.org/doi/full/10.1056/NEJM199405263302107#t=article>.

130. *Id.* at 1499.

brain function.¹³¹ These complexities led one organization to argue that removing life support from Terri, on the basis of her persistently vegetative state, was morally equivalent to euthanizing the disabled.¹³²

Before the 1999 amendments, “persistent vegetative state” was an example of a type of “terminal condition” and not an end-of-life category of its own.¹³³ Even then, it was regarded by many as a drafting error,¹³⁴ because a “persistent vegetative state” is, by definition, not terminal. A persistent vegetative state may either linger indefinitely, or slowly improve—indeed, in many cases, patients in a persistent vegetative state have a significant chance of recovery.¹³⁵ Certainly, the Florida legislature did not intend to encourage the removal of life support from patients who could get better. Yet, the 1999 amendments to the Advance Directive Statute elevated “persistent vegetative state” to its own bright-line statutory category, alongside “terminal condition” and “end-stage condition.”

B. *Terri's Unknowable Intent*

The Advance Directive Statute and the Florida Supreme Court agree that any inquiry regarding the removal of life support from an incapacitated patient should include a hard look at the evidence of the patient's intent. Further, the burden of proof on the party seeking to remove life support is, and should be, a high one. According to the statute, a party petitioning for the removal of life-sustaining treatments must prove, by clear and convincing evidence, that the decision is the one that the incapacitated patient would have wanted, or, at the very least, that the decision is in the patient's best interest.¹³⁶

In other words, the Advance Directive Statute creates a simple burden-shifting mechanism. The party wishing to withdraw life support from an incapacitated patient has the initial burden of proving that the patient would have wanted to withdraw treatment.¹³⁷ An “interested

131. *See id.*

132. Brief of Amici Curiae Not Dead Yet et al. In Support of Appellant and Requesting Reversal, *Bush v. Schiavo*, 885 So. 2d 321 (Fla. 2004) (No. SC04-925), 2004 WL 1713757 at *1–2.

133. Cava, *supra* note 19 at 8.

134. *Id.*

135. See Special Article, *supra* note 129 (“The condition may be transient, marking a stage in the recovery from severe acute or chronic brain damage, or permanent, as a consequence of the failure to recover from such injuries.”).

136. FLA. STAT. § 765.401(h)(3) (2012) (“. . . a proxy's decision to withhold or withdraw life-prolonging procedures must be supported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent or, if there is no indication of what the patient would have chosen, that the decision is in the patient's best interest.”).

137. *See id.*

party”, such as a family member of the patient, then has the option to oppose the petition, and present evidence of a contrary intent.¹³⁸

Superficially, the Schiavo case seems to have followed this statutory back-and-forth. Michael Schiavo presented evidence that he claimed evinced an intent on Terri’s part to withdraw from life support. Terri’s family attempted to refute this evidence, and lost. Terri’s life support was then removed. Yet, commentators who claim that this case is a textbook example of how the Advance Directive Statute is meant to work¹³⁹ are only half-right. All of the briefs, decisions, and publicity of the Schiavo case have obscured one notable constitutional fact—the Advance Directive Statute requires clear and convincing evidence, and Michael did not have it.

Michael Schiavo attempted to meet his burden of proof using hearsay statements that Terri had allegedly made to him, her friends, and her family. These statements were few, and they were vague.¹⁴⁰ Yet, despite the paucity of his evidence, Michael was, understandably, passionate in his belief that Terri would not have wanted to live in a vegetative state.¹⁴¹

Terri’s parents, Robert and Mary Schindler, took advantage of their statutory right to challenge Michael’s petition to remove Terri’s life support.¹⁴² The Schindlers attacked Michael, claiming he wanted to kill Terri in order to inherit her money¹⁴³ and marry one of the women he had been romantically involved with since Terri’s accident.¹⁴⁴ And the

138. FLA. STAT. § 765.105 (2012) (“The patient’s family, the health care facility, or the attending physician, or any other interested person who may reasonably be expected to be directly affected by the surrogate or proxy’s decision concerning any health care decision may seek expedited judicial intervention pursuant to Rule 5.900 of the Florida Probate Rules, if that person believes: (1) The surrogate or proxy’s decision is not in accord with the patient’s known desires or the provisions of this chapter; (2) The advance directive is ambiguous, or the patient has changed his or her mind after execution of the advance directive; (3) The surrogate or proxy was improperly designated or appointed, or the designation of the surrogate is no longer effective or has been revoked; (4) The surrogate or proxy has failed to discharge duties, or incapacity or illness renders the surrogate or proxy incapable of discharging duties; (5) The surrogate or proxy has abused powers; or (6) The patient has sufficient capacity to make his or her own health care decisions.”).

139. See Edward J. Larson, *From Cruzan to Schiavo: Similar Bedfellows in Fact and at Law*, 22 CONSTITUTIONAL COMMENTARY 405, 405 (2005) (“Whatever else may be said about it, Terri Schiavo’s death was legal. It scrupulously complied with Florida state law.”).

140. *Schiavo I*, 780 So. 2d at 180.

141. *Dateline: ‘It’s My Turn to Talk, Says Michael Schiavo* (NBC television broadcast Mar. 24, 2006), available at http://www.msnbc.msn.com/id/11943750/ns/dateline_nbc/t/its-my-turn-talk-says-michael-schiavo/#.UWBrQ5OG3zw.

142. Snead, *supra* note 123 at 59–71, 88.

143. *Schiavo I*, 780 So. 2d 176, 178 (Fla. Dist. Ct. App. 2001).

144. *Schindler v. Schiavo (In re Guardianship of Schiavo)*, 800 So. 2d 640, 643 (Fla. Dist. Ct. App. 2001) [hereinafter *Schiavo II*]; see also *Terri Schiavo’s Parents Exhaust Legal Options*, CNN.COM (Mar. 27, 2005), <http://transcripts.cnn.com/TRANSCRIPTS/0503/27/sm.02.html>.

Schindlers produced their own witnesses, including two of Michael's former girlfriends (and one girlfriend's husband), who testified that Michael had invented his statements of Terri's intent.¹⁴⁵

Despite its weaknesses, Michael's evidence carried the day. Even though Florida courts apply a presumption that a patient would wish to be kept alive,¹⁴⁶ and even though the Advance Directive Statute requires "clear and convincing" evidence of patient intent, one judge after another ruled that Michael's hearsay evidence sufficed to remove Terri's life support.¹⁴⁷ In 2005, fifteen years after Terri first collapsed, her feeding tube and hydration were finally removed, and she died of starvation and dehydration about two weeks later.¹⁴⁸

This is not, however, the complete story of the Schiavo case. In fact, the true significance of the Advance Directive Statute's application to Terri Schiavo has been almost entirely ignored. The fight over Terri's treatment spawned scores of appellate and trial court rulings and two probably unconstitutional statutes, one passed by the Florida legislature¹⁴⁹ and one passed by the United States Congress.¹⁵⁰ Yet it failed to spark more than a superficial discussion of what should have mattered most—Terri's intent.

C. *The Second District Court of Appeal's Opinions in Schiavo*

Michael's legal fight with the Schindlers cycled through multiple appeals at different levels, including a series of three published decisions by Florida's Second District Court of Appeal. Yet, in all of that legal paper, only a few words were devoted to what Terri would have wanted, had she been capable of expressing herself. The rest focused on a medical category whose meaning changed from party to party, lawyer to lawyer, court to court, and even from day to day. The three Second District decisions, in particular, illustrate the degree to which the "persistent vegetative state" category has flummoxed the courts and obscured *Browning's* focus on patient intent and autonomy.

The Second District clearly attempted to take a reasoned, compassionate approach to a difficult dispute, while honoring both *Browning*

145. *Schiavo II*, 800 So. 2d at 643.

146. *Id.* at 645.

147. *See id.* at 642–43.

148. *Recent Developments*, *supra* note 119, at 360.

149. *See Bush v. Schiavo*, 885 So. 2d 321, 324 (Fla. 2004) (declaring that Terri's Law "violates the fundamental constitutional tenet of separation of powers and is therefore unconstitutional both on its face and as applied to Theresa Schiavo.").

150. *See Schiavo ex rel. Schindler v. Schiavo*, 357 F. Supp. 2d 1378, 1382–84 (M.D. Fla. 2005) (declining to expressly declare U.S. Public Law 109-3, An Act for the Relief of the Parents of Theresa Schiavo, unconstitutional, but nevertheless refusing to apply the law).

and the Advance Directive Statute. This proved nearly impossible. In its first opinion, the Second District devoted two meager sentences to Michael's evidence of Terri's final wishes, and instead focused largely on the severity of Terri's injuries, and the impossibility of her recovery.¹⁵¹ In its second opinion, the Court opined that a re-hearing of the trial court's order to remove Terri's life support would only be appropriate if Terri suddenly developed a chance of being completely cured.¹⁵² This hypothetical discussion of rehearing on the basis of a miracle cure created a mess on remand, causing the Second District to apologize in its third opinion for the "confusion" created by the second opinion.¹⁵³

Throughout the three decisions, the question of Terri's condition predominated over all other inquiries. In its first decision, the Second District noted that "[m]edicine cannot cure this condition. Unless an act of God, a true miracle, were to recreate her brain, Theresa will always remain in an unconscious, reflexive state, totally dependent upon others to feed her and care for her most private needs."¹⁵⁴ Yet, by the time of the third decision, the Schindlers' medical experts had convinced the skeptical Second District Court of Appeals to order an evidentiary hearing to determine whether Terri would have wanted to undergo a new therapy that had a slim chance of restoring some degree of her cognitive functions.¹⁵⁵

In other words, the courts simply did not take Terri's wishes—or lack thereof—into account. Instead, the courts apparently proceeded under the assumption that a persistent vegetative state was simply such an awful state of existence that no reasonable person would want to live while experiencing it. As long as Michael could prove that Terri was indeed in a persistent vegetative state, the courts would be willing to

151. See *Schiavo I*, 780 So. 2d 176, 177–78, 180 (Fla. Dist. Ct. App. 2001) ("Her statements to her friends and family about the dying process were few and they were oral. Nevertheless, those statements, along with other evidence about Theresa, gave the trial court a sufficient basis to make this decision for her.").

152. *Schindler v. Schiavo (In re Guardianship of Schiavo)*, 792 So. 2d 551, 560 (Fla. Dist. Ct. App. 2001) [hereinafter *Schiavo III*] ("Certainly, if medical research suddenly discovered a complete cure for what had previously been thought to be a terminal condition as defined in section 765.101(17), Florida Statutes (2000), we would treat that new circumstance as a matter warranting relief from such a judgment.").

153. *Schiavo II*, 800 So. 2d 640, 644 (Fla. Dist. Ct. App. 2001) ("We conclude that our examples misled the trial court into believing that only those types of allegations would suffice, and we apologize for the confusion we created.").

154. *Schiavo I*, 780 So. 2d at 177.

155. *Schiavo II*, 800 So. 2d at 644. ("Purely from a lay perspective, this court must express skepticism concerning Dr. Webber's affidavit. Nevertheless, when a doctor claims under oath that he may be able to restore Mrs. Schiavo's ability to speak and otherwise restore her cognitive function, and when numerous doctors dispute the diagnosis of persistent vegetative state based on the records available to them, it is difficult for judges untrained in any medical specialty to summarily reject their opinions without additional evidence.").

overlook the utter paucity of evidence of Terri's intent. This warps *Browning* beyond all recognition. Indeed, it represents the exact outcome that conservatives feared when *Browning* was released, and attempted to correct with the 1999 amendments to the Advance Directive Statute.

The Second District's focus on whether Terri was in a terminal condition or a persistent vegetative state reveals two fundamental, constitutional flaws in the Advance Directive Statute. First, the statute places too much emphasis on vaguely defined clinical criteria as conditions precedent to the removal of life support. This emphasis on medical determinations apparently encouraged the Court to view "persistent vegetative state" or "terminal condition" as a pre-condition to the removal of life support, on par with proof of Terri's wishes. This inquiry had no relation to an actual determination of Terri's wishes.

Second, the Schiavo decisions also reveal the difficulty courts and legislatures have in interpreting specialized medical designations. For example, in its second *Schiavo* decision, the Second District characterized Terri as having a "terminal condition" under the Advance Directive Statute.¹⁵⁶ This is an accurate characterization that reveals the statute's patent absurdity—Terri had a "terminal condition" because she had a condition that, "without treatment, can be expected to cause death."¹⁵⁷ Yet, as the Court noted in its previous decision, Terri had "sufficient money and strength of body to live indefinitely" with the aid of a feeding tube.¹⁵⁸ In other words, Terri was found to have a "terminal condition" because she would die without food and water.

By inserting "persistent vegetative state" into the statute, and retaining "terminal condition," the legislature stymied its own policy goals and created lasting confusion for doctors, patients, and judges. The legislature in 1999 was concerned with protecting the vulnerable. Yet the statute produced by that legislature removed protection from some of the most vulnerable patients in hospitals—those in persistent vegetative states. As the Schiavo case demonstrates, courts will rely on the terminal/ end-stage/ persistent vegetative state language to allow the removal of life support, based on clear and convincing evidence that a patient fits into a particular medical state, and not that such a decision would have been made by the patient herself.

At the same time, the Advance Directive Statute, as amended, obscures the right of patients to determine what medical care they do or

156. *Schiavo III*, 792 So. 2d at 560 ("Her condition is legally a 'terminal condition.'") (citing Fla. Stat. § 765.101(17) (2000)).

157. FLA. STAT. § 765.101(17) (2012).

158. *Schiavo I*, 780 So. 2d at 180.

do not receive at the end of their lives. In Terri's case, the terminal/ end-stage/ persistent vegetative state restrictions served to draw the courts' attention away from the inquiry into patient intent mandated by *Browning*. But they could just as easily serve to limit the ability of a patient with an explicit living will to determine his fate.

V. CONCLUSION

No empirical evidence exists on how doctors, hospital ethics panels, and healthcare attorneys are interpreting and applying the Advance Directive Statute on a day-to-day basis. But anecdotal evidence indicates that the Statute's terminal and end-stage condition restrictions are being used to force some patients to remain on life support, even when the patients have no hope of recovery and have left clear living wills.¹⁵⁹ As one person familiar with hospital procedures regarding end-of-life care put it, doctors in Florida "have become their own risk managers."¹⁶⁰ Now, in some cases, even conscious patients are not allowed to exercise their right to refuse medical treatment.¹⁶¹ Moreover, national studies have found that, even in states without bright-line restrictions like those found in Florida's statute, doctors fail to adequately educate patients and their families on end-of-life care.¹⁶² They tend to err on the side of both aggressive and invasive over-treatment.

Perhaps, then, this is a simple example of hard cases making bad law. The truth is, the vast majority of Americans are just not educated on end-of-life care. And Americans' lack of knowledge regarding the stupefying choices posed by modern life support creates enormous problems for courts, legislators, and hospitals. We hope to protect the vulnerable, while respecting the time-honored sanctity of individuals to do with their own bodies what they please. Yet how can individuals determine what to do with their bodies when they do not even know what the options are?

While I was writing this paper, my mother prepared her living will, designating my sisters and me as her surrogates. My mother was adamant that she wanted to allow nature to take its course in the event of a debilitating illness. Yet, when I began to discuss with her some of the

159. Cossetti, *supra* note 72, at 16 ("At the outset, doing away with the terminally ill requirement was endorsed by various health care providers, a series of attorneys, and the Florida Board of Medicine. The vast majority of the Panel for the Study of End-of-Life Care supported the removal of the terminally ill requirement, under the impression that physicians might refrain from classifying a patient as terminally ill since the phrase may be interpreted differently depending on who is examining the patient.").

160. Telephone Interview with Kenneth Goodman, *supra* note 73.

161. Goodman, *Commentary*, *supra* note 19.

162. See Channick, *supra* note 32.

more difficult life support scenarios that I learned of in my research, she hesitated. She was prepared to order that life support be removed if she was kept alive only by a respirator, and would die within minutes of its removal. But she was less-than-enthusiastic when I broached the subject of a coma, or persistent vegetative state, or partial brain atrophy, in which she would only die, like Terri Schiavo, after days or weeks of starvation or dehydration. It was an uncomfortable conversation, and I can see why doctors and attorneys are hesitant to have it with the people who count on them for advice.

The truth is that there is no easy answer to the quandary posed by modern end-of-life care. Until the previous century, death for human beings had always been an intimate, family- and community-oriented affair. Now, the involvement of hospitals and states gives death an industrial, bureaucratic component that presents enormous benefits, but also significant risks.

Florida's attempt to balance these risks and benefits is a failure. The law should encourage positive approaches to hard problems. In this case, the Advance Directive Statute should encourage frank discussions between patients, doctors, and lawyers regarding end-of-life care. It should promote the capacity of Floridians, as educated citizens of a state with an explicit constitutional privacy right, to determine how and when they receive medical care. And it should protect the vulnerable from the abuse inherent in a medical system characterized in no small degree by cost considerations.

Yet this is not what the Advance Directive Statute does. Instead of promoting the personal autonomy guaranteed by the state's constitution and highest court, the statute injects a bright-line restriction on withdrawing treatment. This restriction was clearly not given the thought or debate that it deserved. And instead of protecting the vulnerable, the statute focuses the attention of decision makers on vague, poorly defined clinical criteria.

This is not to say that there should be no restrictions on individuals' right to refuse treatment. Life support should never be withdrawn from incapacitated patients with a chance of meaningful recovery, or even from patients who will not fully recover, but who nevertheless would wish to continue receiving life-sustaining treatments. Further, hospitals and governments should not be in the business of assisting their patients to commit suicide, or of determining that some lives are not worth preserving. But the terminal/ end-stage/ persistent vegetative state categories only partially serve these worthy ends.

The Florida Legislature may have had good reason to fear that *Browning* went too far in the direction of self-determination. But the

constitutionally proper and practically effective response would have been to work within *Browning's* framework rather than to abandon it. *Browning* and its progeny allow for proof- and policy-based restrictions on the right to refuse medical treatment. Both types of restrictions, if carefully applied, can sufficiently protect vulnerable patients from abuse, while allowing hospitals to respect the wishes of patients who truly have no hope of recovery.

Further, an increased emphasis on evidentiary restrictions would logically encourage a broader discussion of the decisions patients may have regarding their end-of-life care. This discussion could, in turn, help to solve the conundrum faced by courts and hospitals examining a petition to remove life support from an incompetent patient. If the patient's wishes were truly reliable, and the patient's condition truly hopeless and irreversible, then the hardest case would become just a little easier.