IN THE SUPREME COURT OF FLORIDA



----------X

IN RE: GUARDIANSHIP OF :
ESTELLE M. BROWNING

STATE OF FLORIDA
PETITIONER

v.

DORIS F. HERBERT, ETC.
RESPONDENT

..... X

Case No. 74-174
No. 88-2887
Pinellas County Probate Div.
No. 87-1176-6D-3

# BRIEF ON BEHALF OF AMICUS CURIAE CONCERN FOR DYING IN SUPPORT OF RESPONDENT

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Winfield v. Div. of Pari-Mutuel Waaering. 477 So.2d 544 (1985) . . . . . 5. 18

Wons v. Public Health Trust of Dade County. 500 So.2d 679 (Fla. 3rd DCA 1987). aff'd. 541 So.2d 96 (Fla. 1989) . . . . . 5. 18

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**MISCELLANEOUS**

American Medical Association, Report of the Board of Trustees on Living Wills, Durable Powers of Attorney, and Durable Powers of Attorney for Health Care (1989) . . . . . 20

Annas, "Do Feeding Tubes Have More Rights Than Patients ?", 16 Hastings Center Report 26 (Feb. 1986) . . . . . 8

Annas, "When Procedures Limit Rights: From Quinlan to Conroy", 15 Hastings Center Report 24 (1985) . . . . . 20

Asher, "Management of Neurologic Disorders: The First Feeding Session", in Groher (ed.), infra (1984) . . . . . 26

Brennan, "State Constitutions and the Protection of Individual Rights", 90 Harv. L. Rev. 489 (1977) . . . . . 6

Calabresi and Bobbitt, Tragic Choices (1978) . . . . . 29

Capron, "Informed Consent in Catastrophic Disease Research and Treatment", 123 U. Pa. L. Rev. 340 (1974) . . . . . 22

Ciocon, et al., "Tube Feedings in Elderly Patients: Indications, Benefits and Complications" 148 Arch. Intern. Med. 429 (1988) . . 11

Dresser and Boisaubin, "Ethics, Law and Nutritional Support" 145 Arch. Intern. Med. 122 (1985) . . . . . 16

Faden and Beauchamp, A History and Theory of Informed Consent (1986) . . . . . 4, 5

Gerety, "Redefining Privacy", 12 Harv. C.R.-C.L.L. Rev. 233 (1977) . . . . . 4

Groher (ed.), Dysphagia: Diagnosis and Management (1984) . . . 25, 26

Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying (1987) . . . . . 9, 16, 21, 28

Johnson and Grant, The Nursing Home in American Society (1985) . . . . . .

Joint Commission on the Accreditation of Health Care Organizations, Hospice Standards Manual (1986) . . . . . 16

Joint Commission on the Accreditation of Health Care Organizations, Long Term Care Standards Manual (1988) . . . . 13, 16

Lo and Johnson, "Clinical Decisions to Limit Treatment", 93 Ann. Int. Med. 764 (1980) . . . . . 28

Logemann, Evaluation and Treatment of Swallowing Disorders (1983) . . . . . 25

Lynn (ed.), By No Extraordinary Means (1986) . . . . . 10, 11

Lynn, "Conflicts of Interest in Medical Decision-Making", 36 J. Am. Geriatrics Soc. 945 (1988) . . . . . 22

Lynn, "Legal and Ethical Issues in Palliative Care", 12 Seminars on Oncology 476 (1985) . . . . . 17

Lynn and Childress, "Must Patients Always Be Given Food and Water ?", in Lynn (ed.), supra, 47-60 (1986) . . . . . 17

Maynard and Muth, "The Choice to End Life as a Ventilator-Dependent Quadriplegic", 68 Arch. Phys. Med. Rehab 862 (1987) . . 27

Medical Economics Company, Physicians' Desk Reference (1985) . . . . . 11

Meisel, "The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability By Way of Informed Consent", 56 Neb. L. Rev. 51 (1977) . . . . . 4

Miller, "Evaluation of Swallowing Disorders", in Groher (ed.), supra (1984) . . . . . 25

National Hospice Association, The 1988 Guide to the Nation's Hospices (1988) . . . . . 17

Neu and Kjellstrand, "Stopping Long-Term Dialysis: An Empirical Study of Withdrawal of Life-Supporting Treatment", 314 N. Eng. J. Med. 14 (1986) . . . . . 27

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Foreao Life-Sustaining Treatment (1983) . . . . . 8, 9, 16, 21, 23, 24, 28

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions, Vol. I (1982) . . . . . 4, 21, 24

Prosser, Torts (1971 ed.) . . . . . 1

Restatement Torts (1934) . . . . . 1

Restatement (Second) Torts (1965) . . . . . 1

Rhoden, "Litigating Life and Death", 102 Harv. L. Rev. (1988) . . . . . 18

Ruark, "Initiating and Withdrawing Life Support" 318 N. Eng. J. Med. (1988) . . . . . 16

Rulkin and Lukashok, "Rx for Dying: The Case for Hospice Care" 318 N. Eng. J. Med. 376 (1988) . . . . . 16

Schmitz and O'Brien, "Observations on Nutrition and Hydration in Dying Cancer Patients", in Lynn (ed.), supra 29-38 (1986) . . . . . 17

Schultz, "From Informed Consent to Patient Choice: A New Protected Interest", 75 Yale L. J. 219 (1985) . . . . . 4

Smith, "Antecedent Grounds of Liability in the Practice of Surgery", 14 Rocky Mt. L. Rev. 233 (1942) . . . . . 2, 18

Steinbrook and Lo, "Artificial Feeding: Solid Ground, Not a Slippery Slope", 318 N. Eng. J. Med. 286 (1988) . . . . . 16

U.S. Congress, Office of Technology Assessment, Life-Sustaining Technologies and the Elderly (1987) . . . . . 9, 10, 21, 26, 28

Warren and Brandeis, "The Right of Privacy", 4 Harv. L. Rev.193 (1890) . . . . . 4, 17

## PRELIMINARY STATEMENT

The central issue in this case is whether Florida law enables a duly appointed guardian to protect the wish of a previously competent person, who is now incurably and irreversibly ill, to forgo artificial alimentation and die a natural death. Because Florida law extends the right of privacy to persons, not feeding tubes, amicus respectfully requests that this Court answer the certified question in the affirmative.

## STATEMENT OF THE FACTS

Amicus adopts the respondent's statement of the facts.

## ARGUMENT

### I. ACCORDING TO SOUND PRINCIPLES OF COMMON LAW, STATUTORY LAW AND CONSTITUTIONAL LAW, PATIENTS MAY NOT BE FORCED TO UNDERGO TREATMENT AGAINST THEIR WISHES

A person's interest in freedom from uninvited contact deserves the greatest protection available under the law. The common law action of trespass for battery preserved the individual's fundamental right to "a reasonable sense of personal dignity." Restatement of Torts, section 18 (1934); Restatement (Second) of Torts, sections 18 and 19 (1965); Prosser, Torts, 34-37 (1971 ed.). Absent evidence of the actual consent or assent of the individual, the person initiating or authorizing the contact was liable for damages. Restatement supra, sections 49-54; Restatement 2d supra, section 892.

Within the context of health care decisionmaking, the common law's protection of personal dignity and integrity expresses itself through the doctrine of informed consent, which states that treatment may not be rendered absent a patient's consent or in violation of the patient's known wishes and preferences. As relevant now as it was when first uttered seventy-five years ago is Justice Cardozo's succinct pronouncement.

> [Every person] of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. Schloendorff v. Society of Mew York Hospital, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914).

Florida courts have embraced the view that treatment rendered without express or implied consent, or in a manner contrary to the patient's express instructions, constitutes an unlawful trespass to the person. Chambers v. Nottebaum, 96 So.2d 716, 718 (Fla. 3rd DCA 1957); Valcin

v. Public Health Trust of Dade County, 473 So.2d 1297 (Fla. 3d DCA 1984), approved in part, reversed in part, 507 So.2d 596 (Fla. 1987); see also, Kirker v. Orange County, 519 So.2d 682 (Fla. 5th DCA 1988).

That the necessity of obtaining a patient's consent means that consent may be refused and, if it is, that such a refusal must be honored, is not a recent development.

> [T]he right of the individual to die of disease or injury, at his election, is paramoun, to the social interest in preserving him by compulsory surgery. *** [T]he individual person, as the one most vitally concerned, is allowed to choose [between the risks of death and disability], even though he may elect the foolish and disastrous course. His death from refusal to accept surgery could not be considered suicide. Smith, "Antecedent Grounds of Liability in the Practice of Surgery", 14 Rocky Mt. L. Rev. 233, 236-237 (1942).

Courts elsewhere have uniformly held that the right to refuse life-sustaining treatment is the logical corollary to the conviction that a patient's consent is the necessary precursor of any treatment; respect for the person requires honoring his or her refusal to consent. Rasmussen v. Fleming, 154 Ariz. 207, 215-216, 741 P.2d 674, 682-83 (1987); In re Gardner, 534 A.2d 947, 950-51 (Me. 1987); Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 429-432, 497 N.E.2d 626, 633 (1986); In re Colyer, 99 Wash.2d 114, 121-22, 660 P.2d 738, 743 (1983); In re Torres, 357 N.W.2d 332, 339-40 (Minn. 1984); In re Storar, 52 N.Y.2d 363, 376, 420 N.E.2d 64, 70 (1981); McConnell v. Beverly Enterprises-Connecticut, Inc., 209 Conn. 692, 553 A.2d 596 (1989); In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). As one court observed,

> The purpose underlying the doctrine of informed consent is defeated somewhat if, after receiving all information necessary to make an informed decision, the patient is forced to choose only from alternative methods of treatment and is precluded from foregoing all treatment whatever. We hold that the doctrine of informed consent - a

> doctrine born of the common-law right to be free from nonconsensual physical invasions - permits an individual to refuse medical treatment. Rasmussen, 154 Ariz., at 216, 741 P.2d at 683.

Florida statutory law affirms that such consent is essential to the lawful administration of medical treatment. The opening section of the Florida Life-Prolonging Procedures Act states, "[E]very competent adult has the fundamental right to control the decisions relating to his own medical care." Fla. Stat. Ann. 765.02. Similar statements exist elsewhere. Fla. Stat. Ann. 400.022 (1) (a); Fla. Stat. Ann. 400.428 (1); see also, Fla. Stat. Ann. 768.46.

Basing treatment decisions on the patient's values affirms the intrinsic value of self-determination in a way that deferring to physicians, no matter how well intentioned they may be, does not.

> More is involved in respect for self-determination than just the belief that each person knows what's best for him- or herself. Even if it could be shown that an expert (or a computer) could do the job better, the worth of the individual, as acknowledged in Western ethical traditions and especially in Anglo-American law, provides an independent -- and more important -- ground for recognizing self-determination as a basic principle in human relations, particularly when matters as important as those raised by health care are at stake. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (hereinafter "President's Commission") Making Health Care Decisions, Vol. I, at 44-45 (1982).

Florida law affirms this view.

> It is the applicable law, and not the opinions of doctors, which determines that an operation by a doctor on a person without the patient's consent or contrary to the patient's express instructions, constitutes an actionable battery. Meretsky v. Ellenby, 370 So.2d 1222, 1224 (Fla. 3rd DCA 1979).

This strong endorsement of the individual's right to maintain a reasonable sense of dignity, by controlling the circumstances under which her personal and physical integrity may be breached, is

consistent with the common law principles on which medical jurisprudence rests. Faden and Beauchamp, A History and Theory of Informed Consent, 25-30 (1986); President's Commission, supra, at 18-31; Meisel, "The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent", 56 Neb. L. Rev. 51, 74-93 (1977); Schultz, "From Informed Consent to Patient Choice: A New Protected Interest", 75 Yale L. J. 219 (1985).

The individual interests at stake are so essential to our way of life that the Florida constitution explicitly protects them. The right to be let alone, also known as the right of privacy, Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc., 379 So.2d 633 (Fla. 1980), upholds the principles of liberty and self-determination embodied in decisions about one's medical care. Satz v. Perlmutter, 360 So.2d 160 (Fla. 4th DCA 1978), approved, 379 So.2d 359 (Fla. 1980). The right of privacy is essential to human individuality and personal conscience. Gerety, "Redefining Privacy", 12 Harvard C.R.-C.L.L. Rev. 233 (1977).

The concept of a constitutional right of privacy evolved from the common law's protections of individual freedom.

> That the individual shall have full protection in person ... is a principle as old as the common law; but it has been found necessary from time to time to define anew the exact nature and extent of such protection. Political, social and economic changes entail the recognition of new rights, and the common law, in its eternal youth, grows to meet the demands of society. [In early times] the "right to life" served only to protect the subject from battery in its various forms; liberty meant freedom from actual restraint ... [N]ow the right to life has come to mean the right to enjoy life, the right to be let alone: the right to liberty secures the exercise of extensive civil privileges. Warren and Brandeis, "The Right of Privacy", 4 Harv. L. Rev. 193 (1890). (Emphasis added)

Thus, whatever the varied interpretations now placed on the "right to life", its roots lie in the notion that lives in being must be permitted to be beings in life, to control their destinies, exercise freedom of conscience, and to map out their lives according to their individual moral compasses. Doe v. Bolton, 410 U.S. 179, at 211-13 (Douglas, J. concurring). The right of privacy enhances the right to life by permitting each person to define that life and its qualities according to his own ideals. Thus, the concept of privacy furthers the protections provided under the doctrine of informed consent.

> [S]ome forms of intimate personal decisionmaking similar to those addressed by informed consent requirements, are protected by the constitutional right of privacy. These are matters of the protection of self-determination. Faden and Beauchamp, supra, at 40.

Without the right of privacy, individuality in any meaningful sense becomes an impossibility.

The Florida constitution specifically refers to the right of privacy and asserts that "Every natural person has the right to be let alone." Florida Constitution, Article I, section 23. This Court has affirmed that the concept of privacy and the right to be let alone are deeply rooted in our heritage and founded upon historic principles of ordered liberty. Winfield v. Div. of Pari-Mutuel Wagering, 477 So.2d 544, 546 (1985). The Florida constitution confirms the right of privacy in such unqualified language that its protections exceed those guaranteed by the federal constitution. Id., at 548.

The right of privacy permits and protects decisionmaking interests in personal matters. South Florida Blood Service, Inc. v. Rasmussen, 467 So. 798 (Fla. 3rd DCA 1985), aff'd, 500 So.2d 533, 535-36 (1987). This includes decisions to refuse medical treatment, Wons v. Public Health Trust of Dade Co., 500 So.2d 679, 686-7 (Fla.

3rd DCA 1987), aff'd, 541 So.2d 96 (Fla. 1989), and to have life-sustaining treatment withheld or withdrawn, John F. Kennedy Memorial Hospital v. Bludworth, 452 So.2d 921 (Fla. 1984); In re Guardianship of Barry, 445 So.2d 365, 370 (Fla. 2d DCA 1984); see also, Satz v. Perlautter, 362 So.2d 160 (Fla. 4th DCA 1978), approved, 379 So.2d 359 (Fla. 1980).

The constitutional protection Florida provides to individuals who, like Estelle Browning, would prefer to die a natural death, corresponds to the position taken by most courts. Rasmussen, supra, 154 Ariz. at 215, 741 P.2d at 670-71; Bartling v. Superior Court, 163 Cal. App.3d 186, 195, 209 Cal. Rptr. 220, 225 (1984); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Brophy, supra; Colyer, supra, 99 Wash.2d at 119-121, 660 P.2d at 741-42; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. den. sub. nom. Garger v. New Jersey, 429 U.S. 922, 97 S. Ct. 319 (1976); Gray v. Romeo, 697 F. Supp. 580, 584-586 (D.R.I. 1988). These decisions and the ruling of the District Court of Appeal in this case demonstrate that state courts and state constitutions are essential guardians and sources of individual liberty. See, Brennan, "State Constitutions and the Protection of Individual Rights", 90 Harv. L. Rev. 489, 491 (1977).

The constitutional protection afforded Estelle Browning's right to refuse treatment cannot be limited by the definitional language contained in the Florida Life-Prolonging Procedures Act. The act itself says as much. Fla. Stat. Ann., section 765.15; see also, Fla. Stat. Ann. section 382.009 (4). The existence of such additional rights is further suggested by the fact that the statute permits patients to include additional instructions, Fla. Stat. Ann. section

765.05 (2), make decisions in the absence of a declaration, id., section 765.07, and use alternative forms even if they antedate the statute's enactment, id., section 765.14. Nowhere does the statute state that a patient may not ask that artificial feeding be withheld or withdrawn, or that such a request, if made, would be invalid. While the Florida legislature may have been unable to go further than it did in attempting to devise a statutory mechanism to facilitate Estelle Browning's exercise of her constitutional right of privacy, this fact should offer no impediment to acknowledging and respecting her constitutionally guaranteed rights. Corbett v. D'Alessandro, 487 So.2d 368, 370 and 372 (Fla. 2d DCA 1986), rev. den. 492 So.2d 1331 (Fla. 1986).

Indeed, the open-ended language of the Florida Life-Prolonging Procedures Act is consistent with the belief that decisions to refuse any form of life-sustaining treatment are best made according to the patient's preferences and best interests. This is suggested by the fact that the statute permits patients to "die naturally" without defining what such a death may be. Such an approach permits individuals to meet death on their own terms and according to the dictates of their personal beliefs. Some will want every available treatment, some only palliative measures[1]; others may fall within a middle range.

> In few areas of health care are people's evaluations of their experiences so varied and uniquely personal as in their assessments of the nature and value of the processes associated with dying. For some, every moment of life is of inestimable value: for others, life without some desired level of mental or physical ability is worthless or burdensome. A moderate degree of suffering may be an important means of personal

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[1] Consistent with this choice, Florida has passed legislation authorizing the delivery of hospice care. Fla. Stat. Ann. sections 400.601-.614.

> growth and religious experience to one person, but only frightening or despicable to another. Helping patients whose very definitions of what counts as health and disease are so different requires the utmost sensitivity and wisdom of health care professionals. "Supportive Care for Dying Patients: An Introduction for Health Care Professionals", President's Commission, Deciding to Forego Life-Sustaining Treatment, 276 (1983).

To fulfill its commitment to self-determination, the law must permit individuals' own definitions of life and death within the context of the right of privacy. Estelle Browning, in executing her Florida declaration with the additional instruction that she be permitted to die a natural death with no artificial feeding, effectively exercised her conscientious choice to define for herself that form of treatment as a life-prolonging procedure. She deliberately and thoughtfully expressed a preference not to be maintained indefinitely in her current condition, and to be permitted a reasonable amount of dignity at the end of her life. Under the Florida constitution, her request is entitled to the fullest respect. Annas, "Do Feeding Tubes Have More Rights Than Patients ?", 16 Hastings Center Report 26 (Feb. 1986).

For these reasons, amicus respectfully requests that this Court answer the certified question in the affirmative.

## 11. THE RIGHT TO FORGO LIFE-SUSTAINING TREATMENT INCLUDES THE RIGHT TO FORGO ARTIFICIAL FEEDING

Because the Florida Life-Prolonging Procedures Act may not impair an individual's constitutional rights, the legislature's failure to define artificial feeding or artificial alimentation as a "life-prolonging procedure", Fla. Stat. Ann. section 765.03 (3), does not mean such treatment may not be forgone. On the contrary, the constitutional and common law right to refuse treatment includes the

right to have artificially provided nutrition or hydration withheld or wi hdrawn.

Artificial alimentation is an invasive intervention using tubes or catheters and, in the case of a gastrostomy or jejunostomy, it requires surgical incision and placement of the tube. The tubes themselves are regulated as medical devices by the United States Food and Drug Administration, 21 C.F.R. 876.5980, and fall within the Administration's functional definition of a life-supporting or life-sustaining device, 21 C.F.R. 860.3 (e). Whether or not such devices fit Florida's statutory definition of a 'life-prolonging procedure,' Fla. Stat. Ann. section 765.03, they are undeniably life-sustaining measures, U.S. Congress Office of Technology Assessment, Life-Sustaining Technologies and the Elderly, 275-329, 445 (1987); Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, 59-62, 140 (1987); President's Commission, Deciding to Forego Life-Sustaining Treatment, at 3.[2] Indeed, if the artificial feeding device were not sustaining Estelle Browning's life, its removal would be of no concern to the State's Attorney.

Artificial alimentation devices or systems gain access to the alimentary tract in any of the following ways:

- by way of a nasogastric tube placed through the nose, down the esophagus and into the stomach;

- by way of a naso-enteral tube placed through the nose, down the esophagus, through the stomach and into either the duodenum or the jejunum;

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[2] Were it not for the fact that artificial feeding appears to be excluded from the statutory definition of what constitutes a life-prolonging procedure, Estelle Browning would be "terminal" for the purposes of the act. In re Guardianship of Estelle Browning, 14 FLW 956, 958 n. 7. Thus, for the purposes of considering the certified question the word "terminal" reflects a legislative determination and not a medical fact.

- by way of a gastrostomy, endoscopically or surgically placed through the abdomen into the stomach: or

- by way of a jejunostomy, surgically placed through the abdominal wall into the small intestine.

U.S. Congress, OTA, Life-Sustaining Technologies, supra, at 280-282.

Another form of feeding is accomplished by way of a subclavian catheter. Id., 283-286.

Induction of a simple nasogastric tube is no easy matter.

> Insertion of this simple plastic tube is uncomfortable and its retention is irritating. If awake and able to cooperate, the patient is asked to swallow water repetitively as the tube, which is lubricated with a tasteless jelly, is passed through the nose and pushed through the posterior pharynx and esophagus into the stomach. The tube is irritating to the nose and causes a gag reflex when it reaches the posterior pharynx, sometimes causing vomiting. The naso-gastric tube continues to pose significant hazards while it is in place. It may cause vomiting and aspiration of the gastric contents, producing a serious aspiration pneumonia. It may irritate the mucosal surfaces, causing bleeding, sometimes severe. Many patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube, a thought which all patients with any degree of consciousness seem to have. These restrained patients may develop pneumonia and serious bedsores because of lack of activity and fixed positions. Patients with some insight are likely to become depressed or angry over being tied down. Major, "The Medical Procedures for Providing Food and Water: Indications and Effects", in Lynn (ed.), By No Extraordinary Means (1986), at 25.

Such a device is clearly very different from a spoon or a straw. McConnell v. Beverly Enterprises-Connecticut, Inc., 209 Conn. 692, 705, 553 A.2d 596, 603 (1989).

The sustenance itself bears scant resemblance to what most people would call "food" and is listed in the Physicians' Desk Reference (PDR). One common formula, Osmolite, described as "an

isotonic liquid food providing complete, balanced nutrition", is composed of the following ingredients:

> Water, hydrolyzed corn starch, sodium and calcium caseinates, medium-chain triglycerides (fractionated coconut oil), corn oil, soy protein isolate, minerals (potassium citrate, calcium phosphate tribasic, magnesium sulfate, magnesium chloride, zinc sulfate, ferrous sulfate, manganous chloride, cupric sulfate), soy oil, soy lecithin, vitamins (choline chloride, ascorbic acid, alpha-tocopheryl acetate, niacinamide, calcium pantothenate, thiamine chloride hydrochloride, pyridoxine hydrochloride, riboflavin, vitamin A palmitate, folic acid, biotin, phylloquinone, cyanocobalamin, vitamin D3) and carrageenan.

Medical Economics Company, Physicians' Desk Reference, 1770 (1985). The Food and Drug Administration has cautioned that the enteral formulas used to feed seriously ill and debilitated patients are "superb media" for bacteria that cause gastroenteritis and sepsis. CCH Food Drug Cosmetic Law Rptr., para. 41,095, p. 41,705 (November 1988); see also, Ciocon et al., "Tube Feedings in Elderly Patients: Indications, Benefits and Complications", 148 Arch. Int. Med. 429 (1988).

One patient's history illustrates the inescapably medical nature of such feeding systems.

> Originally [Nancy Jobes] was fed and hydrated intravenously, then through a nasogastric tube, then a gastrostomy tube. In June, 1985, complications with the gastrostomy tube necessitated an even more direct approach. Since then, Mrs. Jobes has been fed through a j-tube inserted--through a hole cut into her abdmoninal cavity--into the jejunum of her intestine. Water and a synthetic, pre-digested formula of various amino acids are pumped through the j-tube continuously. She has been removed to Morristown Memorial Hospital at least three times because of complications with the j-tube. In re Jobes, 108 N.J. 394, 402, 529 A.2d 434, 438 (1987).

Artificial feeding clearly is not the same as eating. In re Reguena, 213 N.J. Super. 475, 485-86, 417 A.2d 886, 892 (Ch. Div.) aff'd, 213 N.J. Super. 443, 417 A.2d 869 (App. Div. 1986). It is, rather, a form of medical intervention patients may elect to forgo. Accordingly, courts addressing this question have decided that there

is no meaningful legal distinction between artificially provided nu rition and hydration and other forms of life-sustaining interventions, such as respirators or dialysis, and have concluded that the right to refuse treatment includes the right to refuse artificial feeding.

> [A]rtificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding--they are medical procedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.
>
> Furthermore, while nasogastric feeding and other medical procedures are usually well tolerated, they are not free from risks or burdens: they have complications that are sometimes serious or distressing to the patient. Nasogastric tubes may lead to pneumonia, cause irritation and discomfort, and require arm restraints for an incompetent patient. In re Conroy, 98 N.J. 321, 372-374, 486 A.2d 1209, 1235-37 (1985).

See also, Brophy, supra, 398 Mass. at 435-39, 497 N.E.2d at 636-38; In re Peter, 108 N.J. 365, 380-382, 529 A.2d at 419; In re Jobes, 108 N.J. at 413, n. 9, 529 A.2d at 444, n. 9; In re Gardner, 534 A.2d 947, 954-55 (Me. 1987); In re Drabick, 200 Cal. App. 3d 185, ___, 245 Cal. Rptr. 840, 846, n. 9 (Cal. App. 1988); Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dept. 1987); Gray v. Romeo, 597 F. Supp. 580, 587 (D.R.I. 1988); McConnell v. Beverly Enterprises-Connecticut, Inc., 209 Conn. 692, 705, 553 A.2d 596, 603 (1989).

As the second District Court of Appeal observed in Corbett,

> [W]e see no reason to differentiate between the multitude of artificial devices that may be available to prolong the moment of death. *** We are unable to distinguish on a legal, scientific or a moral basis between those measures that sustain -- whether by means of

"forced" sustenance or forced continuance of vital functions. Corbett, supra, at 371.

Because artificial alimentation constitutes a life-sustaining treatment requiring a patient's consent, it constitutes a procedure which patients may lawfully refuse.

For the forgoing reasons, amicus respectfully requests that this Court answer the certified question in the affirmative.

## 111. A GUARDIAN OR OTHER PROPERLY APPOINTED SURROGATE MAY LAWFULLY DECIDE TO FORGO ARTIFICIALLY PROVIDED SUSTENANCE

Under Florida law, a guardian's primary obligation is to honor an adult ward's preferences and to act in the ward's best interests. Fla. Stat. Ann. section 744.361 (3). The law permits adults to express their preferences concerning the administration of life-sustaining treatment, and to designate another person to make any such decision on the patient's behalf. Fla. Stat. Ann. sections 765.04 (1) and 765.05 (2). Even absent a declaration, the law permits a guardian, designated person, family member or relative to make decisions about life-sustaining treatment. Fla. Stat. Ann. section 765.07. This is consistent with accepted practice among accredited nursing homes. Joint Commission on Accreditation of Health Care Organizations, Long Term Care Standards Manual, section RQ 1.4, p. 53 (1988).

Estelle Browning did everything she believed necessary in accordance with Florida law, by filling out a declaration, providing additional instructions, and designating her family physician to act as her surrogate. Doris Herbert has taken the further step of becoming Estelle Browning's guardian. If the law requires more

advance planning than this, it is difficult to conceive what that planning might entail.

Other courts addressing the question of what powers guardians have to decide to withhold or withdraw life-sustaining treatment have followed common sense in concluding that the authority to refuse consent must exist. To conclude otherwise would "require the guardian to approve blindly all medical recommendations. This cannot be what the legislature intended, since to deny conservators the power to withhold consent would render [the statute] meaningless." In re Drabick, 200 Cal. App.3d 185, ___, 245 Cal. Rptr. 840, 849 (Ct. App, 1988); in accord, Rasmussen v. Fleming, 154 Ariz. 207, 220-21, 741 P.2d 674, 687 (1987); In re Hamlin, 102 Wash.2d 810, 815, 689 P. 2d 1372, 1375 (1984); In re Torres, 357 N.W.2d 332, 337 (Minn. 1984); In re Colyer, 99 Wash.2d 114, 129-130, 660 P.2d 738, 746 (1983).

As was observed in Rasmussen,

> [The] right to consent to or approve the delivery of medical care must necessarily include the right to consent to or approve the delivery of no medical care, To hold otherwise would ... ignore the fact that oftentimes a patient's best interests are best served when medical treatment is withheld or withdrawn. To hold otherwise would also reduce the guardian's control over medical treatment to little more than a mechanistic rubberstamp for the wishes of the medical treatment team. This we decline to do. Rasmussen, 154 Ariz. at 221, 741 P.2d 688.

The question presented here is made a good deal easier by the legislature's enactment of procedures intended to identify and promote the known preferences of patients concerning end of life treatment decisions.

The task is also made easier by the care Estelle Browning took to make her wishes known. Her Florida Directive is of great help in ascertaining the nature and seriousness of her intentions. John F. Kennedy Memorial Hospital v. Bludworth, 452 So.2d 921, 926 (Fla.

1984); see also, In re Conroy, 98 N.J. 321, 361, 486 A.2d 1209, 1229-1231 (1985); In re Peter, 108 N.J. 365, 378-79, 529 A.2d 419, 426 (1987); Bartling v. Superior Court, 163 Cal. App.3d 186, 209 Cal. Rptr. 220 (Ct. App. 1984). Such evidence not only shows what Estelle Browning thought, it shows that she thought.

> The existence of a writing suggests the author's seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based on casual remarks. Further, a person who has troubled to set forth his or her wishes is more likely than one who has not to make sure that any subsequent changes are adequately expressed, either in a new writing, or through clear statements to relatives and friends. In re Westchester County Medical Center, 72 N.Y.2d 517, 531, 534 N.Y.S.2d 886, 892-93, 631 N.E.2d 607, 613-614 (1988).

Given the fact that the law permits decisions about life-sustaining treatment to be made in the absence of a declaration, the law must permit individuals who devote the time Estelle Browning has to documenting her wishes, to have surrogates with the power to carry out such decisions on their behalf.

For these reasons, amicus respectfully requests that the Court answer the certified question in the affirmative.

## IV. A DECISION TO FORGO ANY FORM OF LIFE-SUSTAINING TREATMENT IS NOT AND SHOULD NOT BE EQUATED WITH THE ABANDONMENT OF THE PATIENT

A decision permitting patients to forgo artificial feeding does not demonstrate, or permit, a lack of any further care for the dying patient. The obligation of caregivers to provide comfort and palliative care clearly persists, as Florida law makes explicit. Fla. Stat. Ann. section 400.601 (7).

With the administration of such care, the withdrawal of artificial feeding in no way condemns the patient to a painful

.'existence. In fact, artificial feeding sometimes causes such burdensome complications that its withdrawal brings about an increase in the patient's comfort rather than otherwise.[3]

> When a life-sustaining treatment is forgone, and whenever a patient is dying, the treatment team has an obligation to provide Supportive care, to make the patient as comfortable as possible and to assure that adequate symptom control and support will be provided. *** Such care may include a wide variety of measures to provide symptomatic relief, sedation and pain control, skin care, and turning and positioning. Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, 30 (1987).

The use of water and dextrose in place of liquid nutrition, and of ice chips to maintain moisture, are examples of the readily available means of providing comfort for the patient who prefers not to be artificially fed. Dresser and Boisaubin, "Ethics, Law and Nutritional Support", 145 Arch. Int. Med. 122 at 123 (1985). See also, Ruark, "Initiating and Withdrawing Life Support", 318 N. Eng. J. Med. 25, 30 (1988); Rulkin and Lukashok, "Rx for Dying: The Case for Hospice Care", 318 N. Eng. J. Med. 376 (1988); Joint Commission for the Accreditation of Long Term Health Care Organizations (JCAHO), Long Term Care Standards Manual, at 51-53 (1988); JCAHO, Hospice Standards Manual (1986); "Supportive Care for Dying Patients: An Introduction for Health Care Professionals", in President's Commission, Deciding to Foreao Life-Sustaining Treatment, Appendix B, 277-297 (1983). The resources of supportive and palliative care for those who refuse artificial feeding are widely recognized. Steinbrook and Lo, "Artificial Feeding: Solid Ground Not a Slippery Slope", 318 N. Eng.

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[3] The forcible restraining of patients, which can cause or aggravate bedsores, as well as vomiting, aspiration of nutritional formula, pneumonia, and other physical and emotional problems resulting from the administration of artificial feeding (described in Section 11, pp. 9-10 of this brief) are not uncommon results of this procedure.

J. Med. 286, 288 (1988); Lynn, "Legal and Ethical Issues in Palliative Health Care", 12 Seminars in Oncology 476 (1985); Lynn and Childress, "Must Patients Always be Given Food and Water ?", in Lynn (ed.), By No Extraordinary Means, at 52-53 (1986); Schmitz and O'Brien, "Observations on Nutrition and Hydration in Dying Cancer Patients", in Lynn (ed.), supra, at 29-38. There are at least thirty-two hospices available in Florida, whose expertise is the provision of such care. National Hospice Association, The 1988 Guide to the Nation's Hospices, 47-49 (1988).

For these reasons, amicus respectfully requests the Court to answer the certified question in the affirmative.

## V. NO STATE INTEREST OUTWEIGHS ESTELLE BROWNING'S CAREFULLY DELIBERATED AND ARTICULATED WISH NOT TO HAVE HER LIFE ARTIFICIALLY PROLONGED

The right of privacy is fundamental, but not absolute, and even the right to be let alone must be balanced against other interests. Yet in weighing these interests, it is important to maintain a proper perspective on the values at stake. The protection of a society that values privacy depends upon a recognition of the rights of the individual. Warren and Brandeis, supra, 4 Harv. L. Rev. at 219-220.

> Essentially this controversy concerns the question of whether or not the state can insist that a person ... whose condition is irreversible may be required to submit to medical care under circumstances in which the patient prefers not to do so. Gray v. Romeo, 697 F. Supp. 580, 584 (D.R.I. 1988).

For the following reasons, amicus respectfully submits that the state cannot show just cause for countering Estelle Browning's request for a natural death.

1. The state's interest in the preservation of life is not compelling enough to outweigh Estelle Browning's privacy rights.

Under Florida law, the right of privacy is so important that the standard of review called for in assessing a claim of unconstitutional governmental intrusion into an individual's privacy rights is the 'compelling state interest' standard.

> This shifts the burden of proof to the state to justify an intrusion on privacy. The burden can be met by demonstrating that the challenged [action] serves a compelling state interest and accomplishes its goal through the use of the least intrusive means. Winfield V. Div. of Pari-Mutuel Wagering, 477 So.2d 544, 547 (Fla. 1985).

Such a standard incorporates the law's historic commitment to protecting patients against "surgical enthusiasm" and what is currently described as the "technological imperative", Smith, supra, 14 Rocky Mt. L. Rev. at 237; Rhoden, "Litigating Life and Death", 102 Harv. L. Rev. 375, 379 (1988). Because no less intrusive means of feeding Estelle Browning is available, the sole question is whether the state's interest in preserving life outweighs her preference to forgo artificial alimentation.

The preservation of life is a laudable goal for the state, but it is not an unswerving mandate. St. Mary's Hospital v. Ramsey, 465 So.2d 666, 668 (Fla. 4th DCA 1985). According to the reasoning of this Court,

> there is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether, but for how long and at what cost to the individual life may be briefly extended.

Satz v. Perlmutter, 362 So.2d 160, 162, (quoting Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417, 425-426 [Mass., 1977]) approved, 379 So.2d 361 (Fla. 1980); accord, Public

Health Trust of Dade County v. Wons, 541 So.2d 96, 99-100 (Ehrlich, C.J. conc.) (Fla. 1989).

Estelle Browning's condition is grim with continued life-sustaining treatment, and her death is imminent without it. Her condition is irreversible and no one judges her prognosis to be fairly or even remotely favorable. In such circumstances, the state's interest in preserving life is weak.

> [T]he State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. In re Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664, cert. den., 429 U.S. 922, 97, S. Ct. 319, 50 L.Ed.2d 289 (1976).

In a case such as this the patient's interest in self-determination, as exercised in her declaration, outweighs the state's interest in preserving life. In re Conroy, 98 N.J. 321, 486 A.2d 1209, 1226 (1985).

2. Estelle Browning's desire for a natural death does not offend and therefore is not outweighed by the state's interest in preventing suicide.

The state may not base a criminal prosecution on the exercise of a constitutional right. McConnell, supra, 292 Conn. at 710, 553 A.2d at 605; Barber v. Superior Court, 147 Cal. App.3d 1006, 195 Cal. Rptr. 484 (Ct. App. 1983). The law does not regard patients who elect to forgo dialysis, cardiopulmonary resuscitation, artificial ventilation or artificial feeding as self-murderers. See Fla. Stat. Ann., section 782.08. The physician-patient relationship is confidential, not conspiratorial, and it is cruel to attempt to characterize Estelle Browning or Doris Herbert as outlaws.

> [D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit

> suicide. Refusing medical intervention merely allows the disease to take its natural course: if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. Conroy, supra, 98 N.J. at 350-51, 486 A.2d at 1224.

Estelle Browning did not inflict a stroke upon herself. Her wish not to live an artificially prolonged existence cannot be considered either self-murder or euthanasia.

For these reasons, amicus respectfully requests that this Court answer the certified question in the affirmative.[4]

## VI. THE RIGHT OF PREVIOUSLY COMPETENT PATIENTS TO FORGO ARTIFICIAL FEEDING SHOULD NOT BE UNDULY BURDENED BY PROCEDURES THAT DO NOT IMPROVE THE DECISIONMAKING PROCESS

Procedures for exercising constitutional rights should not frustrate their attainment. Sound clinical reasoning that safeguards and balances the important interests present in decisions about life-sustaining treatment does not require an analytic maze. The laudable desire to protect all patients does not justify procedures that would delay and possibly thwart the desired goal of respecting the preferences of a previously competent patient. Annas, "When Procedures Limit Rights: From Quinlan to Conroy", 15 Hastings Center Report 24 (April, 1985).

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[4] Because neither the interests of third parties nor the ethical integrity of the medical profession is implicated on the facts of this case, amicus has not briefed these issues. Amicus notes, however, that the American Medical Association recently endorsed the use of advance directives and that it acknowledges the right of competent and incompetent patients to have their preferences concerning life-sustaining treatment respected. AMA, Report of the Board of Trustees on Living Wills, Durable Powers of Attorney and Durable Powers of Attorney for Health Care, June, 1989.

Life-sustaining treatment decisions on behalf of previously competent patients are distinguished by the fact that it is usually not possible to ask the patient now what he wants. Substituted judgment permits personal choice to survive incompetency and prohibits others from following their preferences instead of the patient's. Substituted judgment, therefore, promotes patient welfare and respects patient self-determination -- two values that guide decisionmaking for competent patients. President's Commission, Making Health Care Decisions, Vol. I, 178 (1982); U.S. Congress OTA, Life-Sustaining Technologies and the Elderly, 118-119 (1987); Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, 28 (1987).

> The substituted judgment standard requires that a surrogate attempt to reach the decision that the incapacitated person would make if he or she were able to choose. As a result, the patient's own definition of "wellbeing" is respected: indeed, the patient's interest in "self-determination" is preserved to a certain extent, given the fundamental reality that the patient is incapable of making a valid contemporaneous choice. President's Commission, Deciding to Forego Life-Sustaining Treatment, 132-134 (1982).

Surrogate decisionmaking of this sort has been adopted here and in other states. Rasmussen, supra, 154 Ariz., at 221-222, 741 P.2d at 688-689; In re Severns, 425 A.2d 156, 159 (Del. Ch. 1980); John F. Kennedy Memorial Hospital v. Bludworth, 452 So.2d 921, 926 (Fla. 1984); Gardner, supra, 534 A.2d at 953; Brophy, supra, 398 Mass., at 433-38, 497 N.E.2d at 631-634; Torres, supra, 357 N.W.2d at 339; In re Jobes, 108 N.J. 394, 413-420, 529 A.2d 434, 443-47 (1987); In re Peter, 108 N.J. 365, 377-80, 529 A.2d 419, 425-27 (1987); In re Conroy, 98 N.J. 321, 356-68, 486 A.2d 1209, 1227-1233 (1985); Colyer, supra, 99 Wash.2d at 128-36, 660 P.2d at 744-50; In re Hamlin, 102 Wash.2d 810, 816-20, 689 P.2d 1372, 1376-78 (1984).

Surrogate decisionmaking enables the patient's beliefs and values to shape decisions about her care when she is no longer able to voice them herself. This may be done by reference to statements made by the patient which clearly indicate that she would wish to forgo treatment under current circumstances, or, failing such explicit proof, by reliable evidence of her values, beliefs and convictions that enables the decisionmaker confidently to believe that the patient, if she could, would expressly decline her current treatment, or failing any such proof, that the cessation of treatment would be in the patient's best interests.

All patients, competent and incompetent, share interests in reasoned clinical decisionmaking even when contemporaneous decision-making by the patient is impossible. While the concept of self-determination is of fundamental importance to informed consent, this mechanism protects other critical interests as well. These include: (1) the protection of the patient's dignity as a human being; (2) the avoidance of fraud and duress: (3) the encouragement of self-scrutiny by the physician; and (4) the encouragement of rational decision-making. Capron, "Informed Consent in Catastrophic Disease Research and Treatment", 123 U. Pa. L. Rev. 340, 364-376 (1974). These interests shape and safeguard the manner in which such decisions are reached, and are related to the patient's privacy interests.

The desire to prevent potential abuses or conflicts of interest does not warrant the procedures suggested by the state's attorney. Lynn, "Conflicts of Interest in Medical Decision-Making", 36 J. Am. Geriatrics Soc. 945 (1988). Florida's Life-Prolonging Procedures Act contemplates that decisions such as this one may be made in the clinical setting. In fact, decisions to forgo such treatment are routinely made in that setting without recourse to the courts. In order to avoid creating the impression that because this case is in

court all such cases should be resolved in court, amicus respectfully urges this Court to provide guidance to the individuals customarily involved in making such decisions -- patients, guardians, family members, physicians and others -- to insure that decisions are appropriately made within the clinical setting and to avoid unnecessary recourse to the judiciary.

As long ago as the Quinlan decision it was observed that

> the practice of applying to a court to confirm such decisions would be generally inappropriate, not only because that would be a gratuitous encroachment on the medical profession's competence, but because it would be unduly burdensome. Decision-making within health care should be primarily within the patient, family, doctor relationship. In re Quinlan, 70 N.J. at 50, 355 A.2d at 669.

Absent a genuine and irresolvable disagreement about the patient's wishes, there is generally no reason for judicial intervention or review. Imposing such a requirement may contribute little to the decisionmaking process, and would permit clinicians to avoid the responsibility of using sound professional judgment in these matters. It can only prove costly to the patient and family.[8]

> [J]udicial review in such cases is costly in terms of time and expense: it can disrupt the process of providing care for the patient ...; it can create unnecessary strains in the relationship between the surrogate decisionmaker and others, such as the health care providers, who may be forced into the role of formal adversaries in litigation; and it exposes ordinarily private matters to the scrutiny of the courtroom and sometimes even to the glare of the

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[8] It can also prove costly to providers. Following the recent trend in such matters, one Florida court has ruled that a patient who prevails in such a case is entitled to an award of counsel fees. Hoffmeister v. Coler, Case No. 88-1519 (Fla. 4th DCA, June 7, 1989) [14 F.L.W. 1380]; in accord, Bartling v. Glendale Adventist Medical Center, 184 Cal. App.3d 97, 228 Cal. Rptr. 847 (Ct. App. 1986), on remand, No. 500735 (Cal. Super. Ct. Los Angeles, Oct. 14, 1987); Bouvia v. Glenchur, 195 Cal. App. 3d 1075, 241 Cal. Rptr. 239 (Ct. App. 1987): Gray v. Romeo, No. 87-0573B (D.R.I. March 8, 1989).

> public communications media. President's Commission, Deciding to Forego Life-sustaining Treatment, 159.

A number of courts, acknowledging that such decisions can and therefore ought to be made at the clinical level, have stated that judicial intervention is customarily not necessary or appropriate. Peter, supra, 108 N.J. at 380, 529 A.2d at 427; Jobes, supra, 108 N.J. at 423-24, 529 A.2d at 449-450; Rasmussen, supra, 154 Ariz. at 223-24, 741 P.2d at 691; Torres, supra, 357 N.W.2d at 341, n. 4; Drabick, 245 Cal. Rptr. at 844, 851.

> No matter how expedited, judicial intervention in this complex and sensitive area may take too long. Thus, it could infringe the very rights that we want to protect. The mere prospect of a cumbersome, intrusive, and expensive court proceeding during such an emotional and upsetting period in the lives of a patient and his or her loved ones would undoubtedly deter many persons from deciding to discontinue treatment. And even if the patient or the family were willing to submit to such a proceeding, it is likely that the patient's rights would nevertheless be frustrated by judicial deliberation. Too many patients have died before their right to reject treatment was vindicated in court. In re Farrell, 108 N.J. 335, 357, 529 A.2d 404, 415 (1987).

The responsibility for ensuring that decisionmaking practices are of high quality is the attending physician's, because access to such technology carries with it the obligation to exercise judgment about its use. President's Commission, Deciding to Forego Life-Sustaining Treatment, at 153-160. With appropriate guidance from this Court, quality decision-making can be assured, and excessive reliance on the court system avoided.

For these reasons, amicus respectfully urges this Court to resolve this case in a manner that will, to the greatest extent permissible, provide the necessary guidance and assurance for professionally responsible decisionmaking at the clinical level, and deter unnecessary recourse to the judicial system.

## VII. ANSWERING THE CERTIFIED QUESTION IN THE NEGATIVE WILL IMPAIR DECISIONMAKING REGARDING THE MEDICAL TREATMENT RENDERED TO INCOMPETENT PATIENTS AND MAY DIMINISH THE QUALITY OF CARE THEY RECEIVE AND THE QUALITY OF LIFE THEY EXPERIENCE

Fettered guardians are unable to make decisions in full accordance with their wards' known preferences and best interests. Further, physicians are not able to treat their patients properly if the decision to initiate certain forms of treatment locks them and the patient into an irreversible situation. Prohibiting guardians from deciding to forgo artificial alimentation will lead to irrational and unnecessary results. For the following reasons, guardians must be able to have treatment withheld or withdrawn.

### 1. If patients are not permitted to have artificial alimentation withheld, it may be administered in circumstances where it is not medically necessary.

As with any other form of medical treatment, artificial alimentation is an intervention whose use or recommendation ought to be occasioned by genuine medical necessity. Different clinical options arise depending on whether failure to eat results from (1) a desire not to eat, (2) difficulties in eating, or (3) difficulties in swallowing. Thus, the precise nature of the patient's eating or swallowing disorder, the extent of limitation, and the potential for recovery, rehabilitation or compensation must be evaluated before artificially provided nutrition can be judged to be appropriate. Logemann, Evaluation and Treatment of Swallowing Disorders (1983); Miller, "Evaluation of Swallowing Disorders", in Groher (ed.), Dysphagia: Diagnosis and Management, 85-110 (1984).

For the profoundly and irreversibly stuporous patient such as Estelle Browning, artificial alimentation may be the only method available to meet her physiological needs. Yet there will be many others who, while incompetent to participate in medical treatment

decisions, are able to eat but with difficulty. Such patients may need adaptive eating utensils, help in eating, or other forms of care. Asher, "Management of Neurologic Disorders: The First Feeding Session", in Groher (ed.), supra, at 133-155. But they do not need artificial feeding, and should not left powerless to refuse it.

As one specialist has observed,

> [R]esorting immediately to tube or gastrostomy feedings in cases of dysphagia is a mistake, particularly if the condition has not been adequately diagnosed and other therapeutic measures have not been tried. The limitations and the compromise of quality of life that this presents to the patient are unacceptable. Groher, supra, at xii.

Unfortunately, it appears that artificial alimentation is sometimes administered for reasons other than medical necessity. The U.S. Congress Office of Technology Assessment (OTA) acknowledged the likely existence of this problem two years ago.

> People who are too weak to feed themselves or who have neurological diseases that make them unable or unwilling to feed themselves are also at risk of malnutrition and dehydration. Most of these people can be hand fed. Hand feeding is time-consuming, however, and it has been alleged that some hospitals and nursing homes use tube feeding because sufficient staff time cannot be allocated to hand feeding. The use of tube feeding for this reason is generally frowned on, and there are no data to indicate whether or how often it occurs. U.S. Congress, OTA, supra, 279.

More recently, the U.S. Department of Health and Human Services, through the Health Care Financing Administration, singled out nasogastric tubes for special regulation. 54 Fed. Reg. 5316 (1989) [to be codified at 42 C.F.R. Part 405 et al.] [proposed February 2, 1989]. The Administration's concern over current uses of nasogastric tubes warranted the proposal that they be used only when "the resident's clinical condition demonstrates that use of a nasogastric tube was unavoidable.'' Id., section 483.25, at 5365-66. The

Administration explicitly proposed the regulation to address "issues and circumstances that are indicative of abuse." Id. at 5334.

Patients must have the legal right to refuse invasive treatment that is administered for staff convenience or as a cost-saving measure. If a guardian, or even a competent patient, is left powerless to contest a physician's determination that the use of a feeding device is "clinically unavoidable", patients who neither need nor want such treatment will be unable to have it withheld. Patients must be able to seek a less intrusive means of treatment as well as refuse treatment that artificially prolongs life.

2. If guardians are unable to have artificial alimentation withdrawn, some patients who might have benefitted from artificial alimentation may not receive it.

A decision to start or attempt any treatment, including a life-sustaining treatment, should not lock the patient into a situation as irreversible as her illness. Competent patients are permitted to begin life-sustaining treatments such as respirators or dialysis machines on a trial basis, and then gauge the efficacy and desirability of continuing with them. Neu and Kjellstrand, "Stopping Long-Term Dialysis: An Empirical Study of Withdrawal of Life-Support Treatment", 314 N. Eng. J. Med. 14 (1986); Maynard and Muth, "The Choice to End Life as a Ventilator-Dependent Quadriplegic", 68 Arch. Phys. Med. Rehab. 862 (1987). This case began with a decision to commence treatment in the hope that Estelle Browning would recover, not that she would remain in the very state she so adamantly wished to avoid -- interminably suspended on the threshold of death.

If guardians and physicians are unable to reverse decisions to use artificial alimentation they may become unwilling ever to begin treatment, out of the fear that if it proves undesirable, they will

not be able to have it withdrawn. U.S. Congress, OTA, supra, 264-65 (1987). If starting treatment is optional, stopping it must also be.

> Adopting the ... view that treatment once started cannot be stopped or that stopping requires much greater justification than not starting is likely to have serious adverse consequences. Treatment might be continued for longer than is optimal for the patient, even to the point where it is causing positive harm with little or no benefit. An even more troubling wrong occurs when a treatment that might save or improve health is not started because the health care personnel are afraid that they will find it very difficult to stop the treatment if, as is fairly likely, it proves to be of little benefit and greatly burdens the patient. President's Commission, Deciding to Forego, supra, at 75.

Time-limited trials are often the best method of evaluating the desirability of any treatment. Lo and Jonsen, "Clinical Decisions to Limit Treatment", 93 Ann. Int. Med. 764, 764-65 (1980).

> [T]he responsible health professional should present to the patient or surrogate the option of starting or continuing a particular life-sustaining treatment on a trial basis, with reevaluation after a specific time. Having a trial period may make it easier to evaluate a life-sustaining treatment if the effectiveness, benefits or burdens are difficult to assess in advance. It is ... preferable to try a treatment and withdraw it if it fails, than not to try at all. A trial period may reduce the patient's fears of losing control of a treatment and "being stuck on machines". It may also reduce the emotional distress if a decision is later made to forgo the treatment. Hastings Center, supra, at 30.

Because it is better to try and fail than never to have tried at all, the law should not give artificial alimentation a life of its own. Florida law acknowledges the authority of a patient or surrogate to decide when "therapeutic strategies directed toward cure and control of the disease alone, outside the context of symptom control, are no longer appropriate." Fla. Stat. Ann. section 400.601 (9). This authority must be clearly shown to encompass decisions regarding

artificial feeding, to ensure that neither personal values nor potentially beneficial treatment are needlessly sacrificed.

For the foregoing reasons, amicus respectfully requests that this Court answer the certified question in the affirmative.

## CONCLUSION

As she neared the end of her life, Estelle Browning deliberately told her neighbors, her sole remaining relative and her personal physician of her earnest wish that her life end naturally and that she not linger indefinitely in an irreversible condition. To preserve her wishes she executed a Florida declaration and authorized her physician to implement her preferences. Her desire for a reasonable sense of personal dignity remains unfulfilled.

The tragedy of her situation, and the momentous nature of the choice she made for herself while competent, should not obscure the question before the Court. Nothing anyone does can alter the fact that Estelle Browning will one day die; the only question is whether she dies according to her own values and beliefs, or according to those of the state. By openly and honestly respecting her conscientious choice we can respect the privacy of and ensure a sense of dignity for all.

> [Honesty] is more than the instrument, it is measurement itself, for it is honesty which allows us to see clearly, and occasionally appreciate, the ways, some subtle and some not honest, by which societies must cope. We want to live but we cannot. *** We want suffering to end, but it will not. Honesty permits us to know what it is to be accepted and, accepting, to reclaim our humanity and struggle against indignity. Calabresi and Bobbitt, Tragic Choices, 26 (1978).

For the reasons stated herein, amicus respectfully requests the Court to answer the certified question in the affirmative.

Respectfully submitted,

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**PROOF OF SERVICE**

I do hereby certify that a copy of the within Motion for Leave was sent first class mail this 14th day of July, 1989 to Michael Markham, Esq., Attorney for Sunset Point Nursing Center, 911 Chestnut Street, Clearwater, Florida, 34617-1368; C. Marie King, Esq., Office of James T. Russell, State Attorney, 5100 144th Avenue North, Clearwater, Florida; Robert Merkle, Esq., Attorney for Nursing Home Action Group, 1401 Court Street, Clearwater, Florida, 34616; George J. Felos, Esq., Attorney for Respondent, 380 Main Street, Suite 200, Dunedin, Florida, 34698; and, Fenella Rouse, Esq., Attorney for Society for the Right to Die, Inc., 250 West 57th Street, New York, New York, 10107.

William Trickel, Jr.