

# Preserving Life or Postponing Death

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Where does one start on a topic as complicated and emotional as the one assigned to this paper, “Preserving Life or Postponing Death”? For a simple answer to things you go to a children’s book. So let’s look at a familiar nursery rhyme. And there we find that the end has come when all the world’s doctors and all the world’s machines can’t give Humpty Dumpty the “quality life”, the “meaningful existence” he had before his tragic crash. But when did Dr. Shell-mender and the Dumpty’s decide to remove the life support system? What led them to their decision?

## I

We must begin this “life or death” subject, or should I say “living or dying”, by organizing some concepts. We must ask what we mean by **Life**; by **Death**; and where **Dying** fits into the picture. Then, when the question arises whether or not to stop aggressive medical measures, we can answer the questions: 1) “Is there a viable reason to keep the vital body organs functioning?” or 2) “Shall we let the climax of dying, namely death, come without opposition?”

As I tried to find the medical and legal definitions for when a person has stopped being alive, or is dead, it was interesting how complicated it can become on paper to die. By one definition a person is dead, but by another he or she is still alive. What aggravates the matter is that the lines of medicine, law and theology converge on this super-sensitive issue, “the conflict between the right to individuality and the prohibition against ending life.”<sup>1</sup> “Medical definitions dealt with man’s physical body. Legal definitions dealt with the interlocking responsibilities of the individual, the family and society.”<sup>2</sup> In the Karen Ann Quinlan case, the New Jersey Supreme Court wrote:

Medicine with its combination of advanced technology and professional ethics is both able and inclined to prolong biological life. Law with its felt obligation to protect the life and freedom of the individual seeks to assure each person’s rights to live out his human life until its natural and inevitable conclusion. Theology... defends the sacredness of human life and defends it from all direct attack.<sup>3</sup>

Death is generally an event that is difficult to pinpoint. Death is always described as the absence of some function—breathing stopped; pulse stopped; brain wave has no movement; no reflex actions present. So what functions are necessary to have life? Does our heart have to pump on its own? Must our lungs suck and blow by themselves? Do all our reflexes have to respond? How much of our brain must do its assigned job for human life—all of it?

Part of the dilemma would be solved if there was a universal definition among man for when a person is dead. *Black’s Law Dictionary* states death as “the cessation of life, permanent cessations of all vital functions and signs.”<sup>4</sup> But what is “life”? I understand it to be the continuation of all vital functions and signs. Can this continuation be with artificial help? What are “all” and “vital” functions? Black’s definition I presume determines death primarily by the traditional tests of breath, heartbeat, reflexes, and the mortis family (rigor, algor, and livor).

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<sup>1</sup> Slicker, William D. “Death with Dignity.” *Case & Comment*, May-June 1985, p. 3.

<sup>2</sup> Benton, Richard G. *Death And Dying*. New York: Van Nostrand Reinhold Co., 1978, p. 1.

<sup>3</sup> Slicker, *ibid*.

<sup>4</sup> *Black’s Law Dictionary*. 5th Ed, 1979, p. 361.

For your information the reflexes that aid in detecting death are:

1. Pupil of the eye, usually dilated in death, will not contract when exposed to light.
2. Eye will not blink when the cornea is touched.
3. No response of eye movement to irrigating the corneas of the ear with ice water.
4. When turning the head quickly from side to side, normally the eyes will momentarily hold the position that they were in and not move with the head. With no reflex the eyes move with the head.
5. Throat or trachea does not respond by gagging when stimulated.
6. No spontaneous respiration (4 minutes must lapse and the carbon dioxide concentration in the blood must be normal).
7. Pupil will not dilate when face, neck, upper trunk is pinched.

Another definition lists death as “the irreversible loss of consciousness or capacity for social intercourse”.<sup>5</sup> Here you might hear the term “irreversible coma”. A variation calls death, “the irreversible disruption of the highest levels of a being’s organization.”<sup>6</sup> But what is the minimal “capacity for social intercourse”? When is loss of consciousness “irreversible”? A phrase which also appears in similar definitions is “meaningful human existence”. The vagueness in all creates more questions rather than answering the ones with which we started.

I sent out some questionnaires to various doctors. One question asked “What criteria do you use to determine that a person is dead?” The one doctor who responded said:

- A. Permanent loss of respiration;
- B. Permanent loss of heart beat;

However, this is not adequate if the patient’s respiration and heartbeat are being mechanically supported by artificial means. In this case, I would have already called in a neurologist and a cardiologist as consultants to dilute the responsibility. They would, in our hospital, require three consecutive flat-line EEG tracings as evidence of brain death.<sup>7</sup>

This brings us to the **brain dead** controversy. In 1963 the French Academy of Medicine accepted the death of the brain as an indication of the “irreversible loss of function of an indispensable organ.”<sup>8</sup> So what is “brain death”? We need a brief physiology and anatomy lesson on the brain before we can discuss the options.

Let’s open the science books to the human brain. The brain is the chief coordinating center of the body and of the personality as a whole. It integrates the activities of the central nervous system. It is divided into distinct regions with specific responsibilities. First of all, we look at the **cerebrum**, or cerebral hemisphere. It is the largest and topmost section of the brain. It is the “human brain” where the mind, that is the “grey matter” as we think of it, is in charge of all the in-going and out-going impulses. Here you find thought, reason, self-awareness, perception of past, present, and future, capacity for love, hope, and trust, the ability to communicate and participate with other people, and to understand nature. The cerebral function is what makes people different from all other animals, plants, and rocks. What takes place here makes us true human beings. The EEG measures this part of the brain. (note: Only two circumstances for recovery from flat brain waves are believed possible—drug overdoses; and body temperature lowered to the point when effectively it is sort of hibernating, a hypothermic state.)

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<sup>5</sup> Benton, *ibid.*, p. 15.

<sup>6</sup> Segerberg, Osborn, Jr. *The Immortality Factor*. Toronto: Clarke, Irwin & Co. Ltd., 1974, p. 270.

<sup>7</sup> Hawkins, Dr. Richard K., M.D., Libertyville, IL, questionnaire, April 1987.

<sup>8</sup> Benton, *ibid.*, p. 17.

We move on to the **cerebellum**. It is located in the lower back of the cranial area. Its duty is to balance and coordinate us. It is the center for emotional control and self-preservation. These qualities you find in the higher class of mammals.

Thirdly, there is the **brain stem** which extends from underneath the cerebellum to the spinal cord. It has three parts, the midbrain, pons, and medulla. Its job is to conduct the messages from the switchboard of cerebral ganglia down through the spinal cord. Also it regulates all the autonomic (involuntary action) functions such as respiration, digestion, glands and the like. (Note that the heart's controlling centers lie mostly within itself.)

With this information we can begin to understand the different brain death theories. There are two schools of thought. One is called the "whole brain theory of death". The other is the "neocortical theory of death". The basic assumption of both is that without the brain controlling the body functions in accord with a prescribed guideline, there is no person. The "whole brain theory" pronounces death when heart beat and breathing stop (heart death). The "neocortical theory" pronounces death when higher brain functions are irreversibly damaged. Which is right? It is possible for someone to sustain an injury that destroy the cerebrum and still continue to have breath and heartbeat without mechanical aids. Basic living animal functions continue except for feeding and cleaning oneself. Is the person dead or alive? How much of the brain must be totally dysfunctional before a person ceases to be a person and becomes a corpse? It depends on the definition you use. One school of thought distinguishes between brain death and cerebral death. Is this a valid distinction?

Five types of physical findings play a part in the different sets of criteria used to diagnose brain death:

(1) **Brain-stem Reflexes**. Lack of response to painful stimuli and lack of spontaneous movement is assumed...(2) **Spontaneous Respiration** ...taking the patient off the ventilator until the carbon dioxide level rises above the threshold for stimulating respiration. (3) **Electroencephalographic Findings**...(4) **Cerebral Blood Circulation**...all (or virtually all) blood circulation in the brain has ceased... results in anoxia...(5) **Clinical History**.<sup>9</sup>

In the 1985 Florida Statutes under Chapter 382, *Vital Statistics*, there is a section (.085) describing, "Recognition of brain death under certain circumstances" which states:

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

(2) Determination of death pursuant to this section shall be made in accordance with currently accepted reasonable medical standards by two physicians...the treating physician, and the other physician shall be a board-eligible or board-certified neurologist, neurosurgeon, internist, pediatrician, surgeon or anesthesiologist.<sup>10</sup>

And there is God's definition. Several passages seem to demonstrate that his life-death definition involves breathing. Look at his vision to Ezekiel in chapter 37:5-9, "Look, I (am the one) who brings to you breath [רוּחַ] and life [חַיָּה]...and the bones came together, bone to bone. I looked, and tendons and flesh appeared on them and skin covered them, but there was no breath [רוּחַ] in them...and breath into these slain, that they may live." Adam was only a pile of dirt until God "breathed into his nostrils the breath [נְשָׁמָה] of life [חַיָּים] (= life principle), and man became a living being [נֶפֶשׁ]" (Ge 2:7). This living being God had equipped

<sup>9</sup> Walton, Douglas N., *Ethics of Withdrawal of Life-Support Systems*, Westport, CN: Greenwood Press, 1983, p. 70-71.

<sup>10</sup> Florida, *Statutes* (1985). Chap 382.

specially to rule the rest of creation. And when Jesus died we are told that “He gave up his spirit [πνεῦμα]” (Mt 27:50), “He breathed out [ἐκπνέω]” (Mk 15:37).

These instances cited in the Bible, however, were not addressed to a time with a medical technology like God has blessed us. Life as God describes I see as more than muscles exchanging gases and pumping hemoglobin. Life on earth for the Christian ends when God’s purpose for that person on earth has ended, when that person’s soul is carried to heaven. For the unbeliever, physical death is when God’s patient grace is motionless at zero and He locks that person’s soul in hell. When does this separation happen? Only God knows. But it does happen. That is why I feel Mt 10:28 is a most valuable passage as well. “Do not be afraid of those who kill the body but cannot kill the soul. Rather, be afraid of the one who can destroy both soul and body in hell.”

The Lord distinguishes between the body [σῶμα] and the soul [ψυχή] of a person. This to me implies that there is a part of a human, a non-physical part, which is not affected by what happens to the body. It is affected by God’s declaration. Man can keep a body’s fluid and muscles functioning even after God has called out the soul. On the other hand, even if a man kills another’s body, I feel that he can’t touch the soul.

## II

You may feel that up to this point the real question of the paper has not been addressed. I would agree if you are looking specifically for how to deal with such and such a situation. But I felt that the previous information was a needed base for what is coming. When the last period is reached, you may feel that same information was left out. I purposely did not go into euthanasia, or ministering to families with terminal illness, or what you do after the choice is made to stop the artificial support. I also felt that the question of beginning such support needed no specific discussion because it uses the same information that determines if cessation is proper.

Having said this let’s move now to the second question I asked in my questionnaire to the doctors. What is “the basic criteria you use to recommend taking someone off a life support system who has not improved to the point of not needing the system.” The response was “No doctor in his right mind would make this recommendation on his own. It is always a consensus of opinion of several consultants (they all get sued). Essentially the same criteria [is used] as in [the criteria used to determine death].”<sup>11</sup>

I began with some assumptions. I presumed that a person would stay on mechanical means unless something showed clearly that the machine should be stopped: either recovery, or the impossibility for life to be recovered in the wisest human judgment, or a directive by the patient (directly or through a living will). For your information attached as Appendix A is Chapter 765 of the 1985 Florida Statutes, *Right to Decline Life-Prolonging Procedures*.

In an article “Death with Dignity” the author listed how some church bodies have dealt with this our question:

The Anglican opinion was expressed in 1965 by its Church Assembly Board for Social Responsibility which held that life is a gift of God and death should be a voluntary surrender. In a dying situation the decision to extend treatment so far, but no further, should take into consideration that death may be God’s will and it may be an act of love to relinquish a life that no longer has meaning as a human person.

In 1980, the United Methodist Church adapted the following statement:

Death With Dignity. We applaud medical science for efforts to prevent disease and illness and far advances in treatment that extend the meaningful life of human beings. At the same time, in varying stages of death and life that advances in medical science have occasioned, we

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<sup>11</sup> Hawkins, *ibid.*

recognize the agonizing personal and moral decisions faced by the dying, their physicians, their families, and their friends. Therefore, we assert the right of every person to die in dignity with loving personal care and without efforts to prolong terminal illnesses merely because the technology is available to do so.”<sup>12</sup>

In part I of this paper we spoke almost entirely about life vs. death. Technically speaking a person is either living or he is dead. But sometimes there is this slow, long, drawn out lingering that proceeds death. This I call dying. One court stated: “Individuals have the right to prevent pointless, even cruel, prolongation of the act of dying...a competent adult who is incurable and terminally ill has the right, if he so chooses, not to resist death and to die with dignity.”<sup>13</sup> Keep in mind that

the term death with dignity applies only to those situations where the person is going to die with or without artificial life-prolonging equipment. Death is sure and the only questions are how long and how much suffering will occur before the end...It is erroneously confused with those situations where a patient will live in good health with medical care, but die without it.<sup>14</sup>

There is a concept called **permissive death**. It is based on the principle that life need not be supported for undue periods by extraordinary measures. Prof. Irwin J. Habeck in an article entitled “Euthanasia” equated this permissive death with passive euthanasia. The definition he quoted was “stopping medication or mechanical stimulants, when there is no prognosis of recovery.”<sup>15</sup> He relates the story of an older member of the congregation with terminal cancer. In ministering to him, the pastor sees the progressive deterioration of physical and mental functions. Threw the call comes that patient is dying. Entering the room is like entering a beehive with all the activity, the tubes, the drugs, the machines, the tests. But in his eyes is a vacant stare. Habeck asked the question, “Did we find ourselves wandering: Why all this fuss? It has been evident for some time that his time was running out. Why not let him die in peace?”<sup>16</sup>

So how do we handle the dilemma? How about these considerations:

1. What is the nature of the disease/injury/condition?
2. How long has this condition existed?
3. What has been the progress to this point?
4. What sort of physical damage has occurred and is it irreversible?
5. What is the prognosis for recovery (recovery defined not simply as the ability to remain alive, but have a life without intolerable suffering that has a God-sanctioned purpose)? Is there a cure?

Most people are willing to suffer the pain of surgery, providing there is hope for health.

6. Is the therapy medically appropriate to cure the patient’s condition?
7. Has the doctor exhausted all his knowledge and resources and given a correct diagnosis to the best of his judgment?
8. What effect will removing the artificial support systems have on the patient?
9. How old is the patient?
10. How does the patient feel about the matter?

Is it wrong for a person in great pain or with a prognosis of terminal disease to want to die and be rid of it? If they have a strong will to live, will they be cured or live longer than if they have accepted that it is time to die? Quoting the words of Prof. Habeck, “As far me, I

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<sup>12</sup> Slicker, *ibid.* p. 4.

<sup>13</sup> *Ibid.* p. 6.

<sup>14</sup> *Ibid.*

<sup>15</sup> Habeck, Irwin J, “Euthanasia.” *Wisconsin Lutheran Quarterly*, Vol. 75, Number 1, (Jan 1978), p. 59.

<sup>16</sup> *Ibid.*

don't want my life to be terminated by men. That puts me squarely against active euthanasia. On the other hand, I do not want men to interfere when the Lord by unmistakable symptoms has shown that the time has come for me to die.”<sup>17</sup>

11. How does the family feel?

If their attitude is hostile or not confident in the doctor, the doctor I interviewed said that he would never stop the life support system. He called it “defensive medicine” (doing everything possible not necessarily for the patient’s benefit, but to avoid malpractice suits).

12. Is it time to let death make its claim without our interference? How far should a physician go in delaying death, if that is what he is doing?

13. Are there any economic factors? What if an older person has said he didn't want his savings wiped out so there is nothing to leave for descendants?

14. Does being an organ donor affect the decision?

The final question which I asked the doctors sought information about the influence organ donation may have in their recommendation. The response said:

none—Organs for transplant should obviously not be “harvested” until the patient has met the above criteria of death. Unfortunately, organ donor teams put much pressure on the doctor to hasten this decision so they can yet “fresher” organs.

Contrary to popular belief, very few harvested organs are useful. In most patients dying of natural causes—arteriosclerosis, strokes, heart attacks, infections, etc. —the organs are usually worthless because of previous damage.

Organ transplant is rarely successful except in young previously healthy donors—individuals killed by accidental injury in whom organs are maintained for a short time in good condition by artificial means (respirator, etc.). **The donor still must be dead.**<sup>18</sup>

15. Does it make a difference if the patient is a believer or an unbeliever? How long do you wait hoping for a lucid interval for resuscitating the soul?

For discussion the doctor I interviewed brought up a most interesting practical exercise. Take the illness pneumonia. Should the doctor vigorously treat the disease, or

fold his hands and piously say “we will withhold treatment because it is the Lord’s will?” What if the patient is a two year old child? Or a twenty year old mother, or a forty year old father with six children, or a sixty-five year old retiree? Or a ninety-six year old great-grandmother who came in the hospital yesterday paralyzed with a stroke, or with terminal cancer?

Where in our training, either medical or Christian have we found a formula which tells us which of those patients should be treated vigorously or half-heartedly, or “be allowed to die with dignity”? I believe God gave us the knowledge, and the instruments to heal or relieve suffering and he intends for us to use them.

However great his knowledge, no matter, how vast his experience, no matter how much love he has for his patients, no physician has the wisdom to answer this question and be consistently right 100% of the time. He must pray for God’s guidance, use his knowledge and skill to the best of his ability, confer with his colleagues and let the Holy Spirit guide him by way of his conscience.

From a practical standpoint this often means he begins treatment vigorously to buy time for evaluation of the patient and his problem. Many times aggressive treatment has been started by

<sup>17</sup> Ibid, p. 61.

<sup>18</sup> Hawkins, *ibid*.

the paramedics in the ambulance, or by the emergency room physician upon arrival. They have no choice because it is their job. It is the attending physician who has to worry about whether or when to “pull the plug”. Fortunately (for the doctor, at least) he is not often forced with this decision—the patient either recovers or goes into irreversible cardiac arrest.<sup>19</sup>

I hope this presentation in some way can help you in your ministry. My experience in the subject above is very little. That is why I find great comfort knowing that when it comes to the physical question on “pulling the plug”, the Christian’s soul ends up in God’s caring hands no matter what advice I give. That does not give me license to take a “so what” attitude toward the matter. Instead, it focuses my attention on the Lord whom I know is the one to guide us to the right decision.

For none of us lives to himself alone and none of us dies to himself alone. If we live, we live to the Lord; and if we die, we die to the Lord. So, whether we live or die, we belong to the Lord.  
Romans 14:7-8

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<sup>19</sup> Ibid.

## Appendix A

Florida *Statutes*, Chapter 765, pp. 1396-1398.

### Right to Decline Life-Prolonging Procedures

765.01 Life-Prolonging Procedure Act of Florida; short title.

765.02 Right to make declaration instructing physician concerning life-prolonging procedures; policy statement.

765.03 Definitions.

765.04 Procedure for making a declaration; notice to physician.

765.05 Suggested form of written declaration.

765.06 Revocation of declaration.

765.07 Procedure in absence of declaration; no presumption.

765.08 Effect of pregnancy on declaration or agreement.

765.09 Transfer of a qualified patient.

765.10 Immunity from liability; weight of proof; presumption.

765.11 Mercy killing or euthanasia not authorized; suicide distinguished.

765.12 Effect of declaration with respect to insurance.

765.13 Falsification, forgery, or willful concealment, cancellation; or destruction of declaration or revocation; penalties.

765.14 Existing declarations; how treated.

765.15 Preservation of existing rights.

**765.01 Life-Prolonging Procedure Act of Florida; short title.**—Sections 765.01-765.15 may be cited as the “Life-Prolonging Procedure Act of Florida.”

History.—s. 1, ch. 84-58.

**765.02 Right to make declaration instructing physician concerning life-prolonging procedures; policy statement.**—The Legislature finds that every competent adult has the fundamental right to control the decisions relating to his own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong his life. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. The Legislature further finds that the artificial prolongation of life for a person with a terminal condition may secure for him only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the patient. In order that the rights and intentions of a person with such a condition may be respected even after he is no longer able to participate actively in decisions concerning himself, and to encourage communication among such patient, his family, and his physician, the Legislature declares that the laws of this state recognize the right of a competent adult to make an oral or written declaration instructing his physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make the treatment decision for him, in the event that such person should be diagnosed as suffering from a terminal condition.

History.—s. 2, ch. 84-58.

**765.03 Definitions.**—As used in ss. 765.01-765.15 the term:

- (1) “Attending physician” means the primary physician who has responsibility for the treatment and care of the patient.
- (2) “Declaration” means:
  - (a) A witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of s. 765.04; or



- (b) A witnessed oral statement made in accordance with the provisions of s. 765.04 by the declarant subsequent to the time he is diagnosed as suffering from a terminal condition.
- (3) “Life-prolonging procedure” means any medical procedure, treatment, or intervention which:
- (a) Utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function; and
  - (b) When applied to a patient in a terminal condition, serves only to prolong the process of dying.
- The term “life-prolonging procedure” does not include the provision of sustenance or the administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.
- (4) “Physician” means a person licensed to practice medicine in the state.
- (5) “Qualified patient” means a patient who has made a declaration in accordance with ss. 765.01-765.15 and who has been diagnosed and certified in writing by the attending physician, and by one other physician who has examined the patient, to be afflicted with a terminal condition.
- (6) “Terminal condition” means a condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty, there can be no recovery and which makes death imminent.
- History.—s. 3, ch. 84-58; s. 65, ch. 85-62.

**765.04 Procedure for making a declaration; notice to physician.—**

- (1) Any competent adult may, at any time, make written declaration directing the withholding or withdrawal of life-prolonging procedures in the event such person should have a terminal condition. A written declaration must be signed by the declarant in the presence of two subscribing witnesses, one of whom is neither a spouse nor a blood relative of the declarant. If the declarant is physically unable to sign the written declaration, his declaration may be given orally, in which event one of the witnesses must subscribe the declarant’s signature in the declarant’s presence and at the declarant’s direction.
- (2) It is the responsibility of the declarant to provide for notification to his attending physician that the declaration has been made. In the event the declarant is comatose, incompetent, or otherwise mentally or physically incapable, any other person may notify the physician of the existence of the declaration. An attending physician who is so notified shall promptly make the declaration or a copy of the declaration, if the declaration is written, a part of the declarant’s medical records. If the declaration is oral, the physician shall likewise promptly make the fact of such declaration a part of the patient’s medical record.

History—s. 4, ch. 84-58.

**765.05 Suggested form of written declaration.—**

- (1) A declaration executed pursuant to s. 765.04 may, but need not, be in the following form:

Declaration

Declaration made this \_\_\_ day of \_\_\_, 19\_\_\_. I, \_\_\_\_, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

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, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

(Signed)

The declarant is known to me, and I believe him or her to be of sound mind.

Witness

Witness

- (2) A declaration executed pursuant to s. 765.04 may include other specific directions, including, but not limited to, a designation of another person to make the treatment decision for the declarant should he be diagnosed as suffering from a terminal condition and comatose, incompetent, or otherwise mentally or physically incapable of communication. Should any other specific direction be held to be invalid, such invalidity will not affect the declaration.

History—s. 5, ch. 84-58.

**765.06 Revocation of declaration.**—A declaration may be revoked at any time by the declarant:

- (1) By means of a signed, dated writing;
- (2) By means of the physical cancellation or destruction of the declaration by the declarant or by another in the declarant's presence and at the declarant's direction; or
- (3) By means of an oral expression of intent to revoke.

Any such revocation will be effective when it is communicated to the attending physician. No civil or criminal liability shall be imposed upon any person for a failure to act, upon a revocation unless that person has actual knowledge of such revocation.

History—s. 6, ch. 84-58; s. 66, ch. 85-62.

**765.07 Procedure in absence of declaration; no presumption.**—

- (1) Life-prolonging procedures may be withheld or withdrawn from an adult patient with a terminal condition who is comatose, incompetent, or otherwise physically or mentally incapable of communication and has not made a declaration in accordance with s. 765.04, if there are a consultation and a written agreement for the withholding or withdrawal of life-prolonging procedures between the attending physician and any of the following individuals, who shall be guided by the express or implied intentions of the patient, in the following order of priority if no individual in a prior class is reasonably available, willing, and competent to act:
  - (a) The judicially appointed guardian of the person of the patient if such guardian has been appointed. This paragraph shall not be construed to require such appointment before a treatment decision can be made under this section.
  - (b) The person or persons designated by the patient in writing to make the treatment decision for him should he be diagnosed as suffering from a terminal condition.
  - (c) The patient's spouse.
  - (d) An adult child of the patient or, if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation.
  - (e) The parents of the patient.
  - (f) The nearest living relative of the patient.
- (2) In any case in which the treatment decision is made, at least two witnesses must be present at the time of the consultation when the treatment decision is made.
- (3) The absence of a declaration by an adult patient does not give rise to any presumption as to his intent to consent to, or refuse, life-prolonging procedures.

History.—s. 7, ch. 84-58.

**765.08 Effect of pregnancy on declaration or agreement.**—The declaration of a qualified patient, or the written agreement for a patient qualified under s. 765.07, which patient has been diagnosed as pregnant by the attending physician, shall have no effect during the course of the pregnancy.

History.—s. 12, ch. 84-58.

**765.09 Transfer of a qualified patient.**—An attending physician who refuses to comply with the declaration of a qualified patient, or the treatment decision of a person designated to make the decision by the declarant in his declaration or pursuant to s. 765.07, shall make a reasonable effort to transfer the patient to another physician.

History.—s. 8, ch. 84-58.

**765.10 Immunity from liability; weight of proof; presumption.**—

- (1) A health care facility, physician, or other person who acts under the direction of a physician is not subject to criminal prosecution or civil liability, and will not be deemed to have engaged in unprofessional conduct, as a result of the withholding or withdrawal of life-prolonging procedures from a patient with a terminal condition in accordance with ss. 765.01-765.15. A person who authorizes the withholding or withdrawal of life-prolonging procedures from a patient with a terminal condition in accordance with a qualified patient's declaration or as provided in s. 765.07 is not subject to criminal prosecution or civil liability for such action.
- (2) The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-prolonging procedures did not, in good faith, comply with the provisions of ss. 765.01-765.15. A declaration made in accordance with ss. 765.01-765.15 shall be presumed to have been made voluntarily.

History.—s. 9, ch. 84-58.

**765.11 Mercy killing or euthanasia not authorized; suicide distinguished.**—

- (1) Nothing in ss. 765.01-765.15 shall be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.
- (2) The withholding or withdrawal of life-prolonging procedures from a patient in accordance with the provisions of ss. 765.01-765.15 does not, for any purpose, constitute a suicide.

History.—ss. 11, 12, ch. 84-58.

**765.12 Effect of declaration with respect to insurance.**—The making of a declaration pursuant to ss. 765.01-765.15 shall not affect the sale, procurement, or issuance of any policy of life insurance, nor shall such making of a declaration be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance will be legally impaired or invalidated by the withholding or withdrawal of life-prolonging procedures from an insured patient in accordance with the provisions of ss. 765.01-765.15, notwithstanding any term of the policy to the contrary. A person shall not be required to make a declaration as a condition for being insured for, or receiving, health care services.

History.—s. 12, ch. 84-58.

**765.13 Falsification, forgery, or willful concealment, cancellation, or destruction of declaration or revocation; penalties.**—

- (1) Any person who willfully conceals, cancels, defaces, obliterates, or damages the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another, and who thereby causes life-prolonging procedures to be utilized in contravention of the previously expressed intent of the patient, is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
- (2) Any person who falsifies or forges the declaration of another or who willfully conceals or withholds personal knowledge of the revocation of a declaration, with the intent to cause a withholding or withdrawal

of life-prolonging procedures contrary to the wishes of the declarant, and who thereby because of such act directly causes life-prolonging procedures to be withheld or withdrawn and death to be hastened, is guilty of a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

History.—s. 10, ch. 84-58.

**765.14 Existing declarations; how treated.**—The declaration of any patient made prior to October 1, 1984, shall be given effect as provided in ss. 765.01-765.15.

History.—s. 12, ch. 84-58.

**765.15 Preservation of existing rights.**—The provisions of ss. 765.01-765.15 are cumulative to the existing law regarding an individual's right to consent, or refuse to consent, to medical treatment and do not impair any existing rights or responsibilities which a health care provider, a patient, including a minor or incompetent patient, or a patient's family may have in regard to the withholding or withdrawal of life-prolonging medical procedures under the common law or statutes of the state.

History.—s. 13, ch. 84-58.

## Bibliography

- Benton, Richard G. *Death And Dying*. New York: Van Nostrand Reinhold Co., 1978.
- Black's Law Dictionary*. 5th ed., 1979.
- Florida, *Statutes* (1985). Chapters 382 & 765, p. 1396-1398.
- Habeck, Irwin J. "Euthanasia." *Wisconsin Lutheran Quarterly*. Vol. 75, Number 1, (Jan 1978), pp. 56-61.
- "Modern Medicine." *Newsweek*. January 19, 1987, p. 71-72.
- Seegerberg, Osborn, Jr. *The Immortality Factor*. Toronto: Clarke, Irwin & Co., Ltd., 1974.
- Slicker, William D. "Death with Dignity." *Case & Comment*, May-June 1985, pp. 3-6.
- Thielicke, Helmut, *The Doctor as Judge of Who Shall Live and Who Shall Die*. Philadelphia: Fortress Press, 1976.
- Walton, Douglas N. *Ethics of Withdrawal of Life-Support Systems*. Westport, CN: Greenwood Press., 1983.
- Witte, Dr. David. Essay delivered to Pastor/Teacher Conference, Northern MI Conference, MI District, Feb 3, 1975.