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## The Virginia Natural Death Act - A Critical Analysis

Janice G. Murphy  
*University of Richmond*

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## THE VIRGINIA NATURAL DEATH ACT<sup>1</sup> — A CRITICAL ANALYSIS

*Don't treat this patient anymore . . . it does not serve either the patient, the family, or society in any meaningful way to continue treatment with this patient.*<sup>2</sup>

The right to die with dignity is a controversial issue. In the absence of legislative guidance, court intervention is often necessary to protect a patient's right to the privacy of his own body.<sup>3</sup> At the same time, courts must protect the state's interests in the preservation of life, the protection of innocent third parties, the prevention of suicide, and the ethical integrity of the medical profession.<sup>4</sup>

This controversy was brought to the nation's attention in a 1982 case involving a Down's syndrome newborn. The child's parents decided against surgery to correct his deformed esophagus. The hospital involved unsuccessfully petitioned the court for an order to require the lifesaving operation.<sup>5</sup> The Indiana Supreme Court denied review of the trial court decision, and the baby died before further appeals could be taken.<sup>6</sup> Indiana had no legislation to guide the court in its decision.<sup>7</sup>

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1. VA. CODE ANN. §§ 54-325.8:1 to -325.8:13 (Cum. Supp. 1983).

2. *In re Quinlan*, 70 N.J. 10, —, 355 A.2d 647, 657, cert. denied, 429 U.S. 922 (1976) (statement of Dr. Julius Korein, a neurologist who testified on behalf of Karen Quinlan).

3. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973). See also *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

4. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, —, 370 N.E.2d 417, 425 (1977). These four factors were listed as legitimate State interests involved in the withholding of treatment from incompetent persons. The court held that the most important of these interests was the preservation of human life, but added that this interest "must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation." *Id.* at —, 370 N.E.2d at 425.

5. *Indiana ex. rel. Infant Doe v. Monroe Cir. Ct.*, No. 482-5140 (Ind. Sup. Ct. Apr. 16, 1982).

6. W. WADDINGTON, C. WHITEBREAD & S. DAVIS, *CHILDREN IN THE LEGAL SYSTEM*, 901 n.1 (1983); Tift, *Debate on the Boundary of Life: Medical Miracles and the Patient's Right to Die*, TIME, Apr. 11, 1983, at 68-69.

7. In addition to Virginia, 13 states and the District of Columbia have natural death or death with dignity legislation. ALA. CODE §§ 22-8A-1 to -10 (Cum. Supp. 1982); ARK. STAT. ANN. §§ 82-3801 to -3804 (Cum. Supp. 1983); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Cum. Supp. 1983); DEL. CODE ANN. tit. 16 §§ 2501-2509 (Cum. Supp. 1982); D.C. CODE ANN. §§ 6-2421 to -2430 (Cum. Supp. 1983); IDAHO CODE §§ 39-4501 to -4508 (Cum. Supp. 1983); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1982); NEV. REV. STAT. §§ 449.540 to .680 (1979 & Adv. Sheets 1983); N.M. STAT. ANN. §§ 24-7-1 to -11 (Repl. Vol. 1981); N.C. GEN. STAT. §§ 90-320 to -323 (Repl. Vol. 1981); OR. REV. STAT. §§ 97.050-.090 (Repl. Vol. 1981); TEX. REV. CIV. STAT. ANN. art. 4590 (Vernon Cum. Supp. 1982-83); VT. STAT. ANN. tit. 18, § 5251 (Cum. Supp. 1983); WASH. REV. CODE ANN. §§ 70.122.010-.122.903 (Cum. Supp.

In California, two Los Angeles doctors were charged with murder for removing the respirator and intravenous food and water sustaining a comatose patient.<sup>8</sup> In this situation, the doctors had apparently crossed the line between passive euthanasia, refraining from taking any action to help or hurt the patient, and active euthanasia, administering a life-shortening agent.<sup>9</sup> The doctors were later acquitted.<sup>10</sup> Unlike Indiana, California had a "Living Will" statute to guide the court.<sup>11</sup> In general, this type of legislation allows a competent person to declare in advance that he does not want extraordinary medical treatments to prolong his life should he become terminally ill.<sup>12</sup> Most of these laws, however, lack similar provisions for the incompetent patient.

In 1983, the Virginia General Assembly passed the Virginia Natural Death Act,<sup>13</sup> which outlines the procedures to be followed in deciding whether to withhold or withdraw medical treatment. The most controversial feature of the legislation is also its primary function: to allow the family and attending physician to make the treatment decision for a patient who is incompetent or otherwise unable to communicate.<sup>14</sup>

This comment will first discuss selected landmark cases that provided the legal setting for the Virginia Natural Death Act. Then, it will address the issues raised by several individuals and groups before the Joint Subcommittee Studying the Rights of the Terminally Ill, which was responsible for researching and developing the Act.<sup>15</sup>

## I. JUDICIAL DECISIONS: TO TREAT OR NOT TO TREAT

In the absence of any Virginia Supreme Court precedent, the Joint

1983-84).

8. TIME, *supra* note 6, at 69.

9. Kutner, *Euthanasia: Due Process for Death with Dignity; The Living Will*, 54 IND. L. J. 201, 201 (1979).

10. Hedlund v. Superior Ct. of Orange County, L.A. No. 31676 (Sup. Ct. Calif. Sept. 29, 1983).

11. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Cum. Supp. 1983).

12. *See, e.g., id.* § 7186.

13. VA. CODE ANN. §§ 54-325.8:1-.8:13 (Cum. Supp. 1983). For a detailed summary of similar provisions in the laws of other states, see Freamon, *Death with Dignity Laws: A Plea for Uniform Legislation*, 5 SETON HALL LEGAL J. 105 (1982). This comment will not compare Virginia's statute to that of other states since many of those statutes are recent and have not been tested by the courts.

14. VA. CODE ANN. § 54-325.8:6 (Cum. Supp. 1983).

15. *See* JOINT SUBCOMMITTEE STUDYING THE RIGHTS OF THE TERMINALLY ILL, REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA OF 1983, H.D. DOC. NO. 32 (1983) [hereinafter cited as REPORT]. Subcommittee members were appointed from the House Committee on Health, Welfare and Institutions (three); the House Committee for Courts of Justice (two); the Senate Committee on Education and Health (two); the Senate Committee on Rehabilitation and Social Services (one); and citizens representing the legal and medical professions and the clergy (five). *Id.* at 4-5.

Subcommittee Studying the Rights of the Terminally Ill looked to an Alexandria Circuit Court opinion dealing with the right-to-die issue.<sup>16</sup> The patient in this case required respiratory therapy and kidney dialysis. His prognosis for recovery was poor, and he had indicated his desire to discontinue all life-sustaining procedures. The issue before the court was whether he was capable of making that decision.<sup>17</sup>

The court first looked to section 37.1-134.2 of the Code of Virginia<sup>18</sup> to determine the legal competence of the patient. Under this section, a court may authorize treatment only upon a finding by clear and convincing evidence that the patient is incompetent or incapable of giving his informed consent to treatment.<sup>19</sup> Employing this standard, the court found the patient legally competent to render decisions regarding his treatment.<sup>20</sup>

After making this initial determination, the court concluded that the patient had the right to refuse treatment, as well as the concomitant right to discontinue such treatment.<sup>21</sup> The case was dismissed after a finding that the state's interests were "overborne by [the patient's] constitutional right of privacy and his right to individual free choice and self-determination."<sup>22</sup> In the absence of legislation, the courts must determine who can make the decision to forego medical treatment, what the parameters of those decisions will be, and whether the court must mediate in every case. These factors have been developed in several landmark cases.<sup>23</sup>

#### A. *In re Quinlan*

One of the most publicized cases involving the right to die is *In re Quinlan*<sup>24</sup> decided by the New Jersey Supreme Court in 1976. Twenty-

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16. *Alexandria Hosp. v. McLellan*, No. 13009 Ch. 1 (Alexandria Cir. Jan. 11, 1982) (Grenadier, J.). The Subcommittee cited this opinion as evidence that legislation was necessary in Virginia. REPORT, *supra* note 15, at 9. The Subcommittee researched several recent cases on the use of artificial life support while drafting the Act. See *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64 (1981); *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Spring*, 405 N.E.2d 115 (Mass. 1980). REPORT, *supra* note 15, at 8. The Subcommittee may not have been aware of other cases involving similar issues. See, e.g., *In re P.V.W.*, 424 So. 2d 1015 (La. 1982); *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

17. *Alexandria Hosp.*, No. 13009 Ch., slip op. at 1.

18. VA. CODE ANN. § 37.1-134.2 (Cum. Supp. 1982).

19. *Id.*

20. *Alexandria Hosp.*, No. 13009 Ch., slip op. at 1.

21. *Id.* The court relied upon *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), and *Satz v. Perlmutter*, 362 So. 2d 160, *aff'd*, 379 So. 2d 359 (Fla. 1980).

22. *Alexandria Hosp.*, No. 13009 Ch., slip op. at 2-3.

23. See *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

24. 70 N.J. 10, 355 A.2d 647 (1976).

two year old Karen Quinlan was in a permanent vegetative coma; she required a respirator to breathe.<sup>25</sup> Karen's father petitioned the court to appoint him her guardian with the express power to authorize "the discontinuance of all extraordinary medical procedures now allegedly sustaining Karen's vital processes and hence her life, since these measures . . . present no hope of her eventual recovery."<sup>26</sup>

After extensive hearings, the New Jersey Supreme Court appointed Karen's father as her guardian.<sup>27</sup> Citing *Eisenstadt v. Baird*,<sup>28</sup> *Griswold v. Connecticut*,<sup>29</sup> and *Stanley v. Georgia*,<sup>30</sup> the court recognized that Karen's right of privacy entitled her to demand or refuse treatment,<sup>31</sup> and that her father had standing to assert these rights on her behalf.<sup>32</sup> Karen's right of privacy was found paramount to the state's interest in the "preservation and sanctity of human life."<sup>33</sup> The court held that "the State's interest . . . weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."<sup>34</sup>

A medical ethics problem arises when doctors must decide whether to terminate the treatment of a patient who could be kept alive by artificial means.<sup>35</sup> The *Quinlan* court labored over this question,<sup>36</sup> and finally concluded that a hospital-based ethics committee should be consulted before discontinuing treatment.<sup>37</sup> If this committee concurs in the physician's decision to cease treatment, the life-support systems can be removed without resulting in civil or criminal liability for any participant.<sup>38</sup>

The *Quinlan* court clarified the extent of its ruling by concluding that "we do not intend to [imply] that a proceeding for judicial declaratory relief is necessarily required for the implementation of comparable decisions in the field of medical practice."<sup>39</sup> Given the detail in the *Quinlan* opinion regarding the procedures to be followed by a third party making

25. *Id.* at —, 355 A.2d at 653-54.

26. *Id.* at —, 355 A.2d at 651.

27. *Id.* at —, 355 A.2d at 671.

28. 405 U.S. 438 (1972).

29. 381 U.S. 479 (1965).

30. 394 U.S. 557 (1969).

31. 70 N.J. 10, — 355 A.2d 647, 663 (citing *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Stanley v. Georgia*, 394 U.S. 557 (1969), *on remand* 225 Ga. 273, 167 S.E.2d 756 (1969); *Griswold v. Connecticut*, 381 U.S. 479 (1965)).

32. *Id.* at —, 355 A.2d at 661.

33. *Id.* at —, 355 A.2d at 663-64.

34. *Id.* at —, 355 A.2d at 664.

35. *Id.* at —, 355 A.2d at 656-60.

36. *Id.* at —, 355 A.2d at 664-69.

37. See Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975) (cited in *In re Quinlan*, 70 N.J. at —, 355 A.2d at 668-69).

38. 70 N.J. at —, 355 A.2d at 671-72. Karen Quinlan is no longer sustained by life support machines, but is still in a coma. TIME, *supra* note 6, at 68-69.

39. 70 N.J. at —, 355 A.2d at 672.

a treatment decision for an incompetent patient, legislation in this area would arguably be unnecessary in New Jersey.

B. *Superintendent of Belchertown State School v. Saikewicz*

With its landmark decision in *Superintendent of Belchertown State School v. Saikewicz*,<sup>40</sup> the Massachusetts Supreme Judicial Court has guided courts throughout the nation in determining how those responsible for an incompetent patient's care should decide whether to withhold or withdraw treatment. Saikewicz, a sixty-seven-year-old, mentally incompetent resident of the Belchertown State School, suffered from leukemia, a disease accompanied by enlarged organs, internal bleeding, weakness, severe anemia, and high susceptibility to infection.<sup>41</sup> The issue in this case was whether to subject Saikewicz to chemotherapy and blood transfusions. Doctors were concerned about Saikewicz's ability to tolerate the chemotherapy and its painful side effects.<sup>42</sup>

The school superintendent and a staff attorney successfully petitioned the Hampshire County Probate Court to appoint a guardian ad litem for Saikewicz. The guardian recommended that no chemotherapy be pursued because of significant adverse side effects and the patient's inability to understand what was happening to him. He felt that these factors outweighed the potential benefit of the treatment — remission lasting a maximum of thirteen months.<sup>43</sup>

The Massachusetts Supreme Judicial Court reviewed the state's interests involved and found them to be either outweighed or cancelled by the privacy interests of the patient.<sup>44</sup> The court further found that both competent and incompetent patients have the right to choose whether to receive life-prolonging treatment since "the value of human dignity extends to both."<sup>45</sup> The court affirmed the probate court's order not to treat Saikewicz.<sup>46</sup> Saikewicz died two months later without pain or discomfort.<sup>47</sup>

Although the *Saikewicz* decision left the establishment of comprehensive guidelines to the legislature,<sup>48</sup> the court applied the "substituted judgment doctrine," which holds that

[T]he decision in cases such as this should be that which would be made by

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40. 373 Mass. 728, 370 N.E.2d 417 (1977).

41. *Id.* at \_\_\_\_\_, 370 N.E.2d at 420.

42. *Id.* at \_\_\_\_\_, 370 N.E.2d at 420-21.

43. *Id.* at \_\_\_\_\_, 370 N.E.2d at 419-20.

44. *Id.* at \_\_\_\_\_, 370 N.E.2d at 424-27.

45. *Id.* at \_\_\_\_\_, 370 N.E.2d at 427.

46. *Id.* at \_\_\_\_\_, 370 N.E.2d at 435.

47. *Id.* at \_\_\_\_\_, 370 N.E.2d at 422.

48. *Id.* at \_\_\_\_\_, 370 N.E.2d at 432 n.18.

the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.<sup>49</sup>

Procedural guidelines for implementing this decision-making machinery already existed in Massachusetts, including the immediate appointment of a guardian and a guardian ad litem. In addition, the court required the guardian ad litem to present before the probate judge "after as thorough an investigation as time will permit, *all* reasonable arguments in favor of administering treatment to prolong the life of the individual involved."<sup>50</sup> After hearing this information, the probate judge must then decide whether to discontinue treatment.<sup>51</sup>

The *Saikewicz* decision expressly rejected the recommendation of the *Quinlan* court regarding consultation with a hospital ethics committee.<sup>52</sup> The Massachusetts court said it took a "dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group . . . ."<sup>53</sup>

### C. *In re Dinnerstein*

In 1978, another Massachusetts court was confronted with a similar issue in *In re Dinnerstein*.<sup>54</sup> The patient in this case was a sixty-seven-year-old woman suffering from Alzheimer's disease and related complications. In 1978 she suffered a stroke which left her completely vegetative, speechless and immobile. Medicare terminated her benefits because she required more custodial care than medical treatment.<sup>55</sup> The patient's son and daughter agreed with the attending physician that a "no-code" order should be entered on the patient's medical record. A "no-code" order ensures that in the event of a cardiac or respiratory arrest no extraordinary measures will be taken to prolong life. The patient's children brought an action for declaratory judgment seeking judicial authorization for the "no-code" order.<sup>56</sup>

The *Dinnerstein* court discussed the important distinction between or-

49. *Id.* at \_\_\_\_, 370 N.E.2d at 430-31.

50. *Id.* at \_\_\_\_, 370 N.E.2d at 433 (emphasis added). This requirement was modified in *In re Spring*, 380 Mass. 629, \_\_\_\_, 405 N.E.2d 115, 123 (Mass. 1980), where the court stated that "we impose no duty to present arguments the guardian ad litem does not believe meritorious and no obligation to take appeals as a matter of course."

51. 373 Mass. at \_\_\_\_, 370 N.E.2d at 434.

52. *Id.*

53. *Id.*

54. 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).

55. *Id.* at \_\_\_\_, 380 N.E.2d at 135 n.1.

56. *Id.* at \_\_\_\_, 380 N.E.2d at 136.

inary and extraordinary medical techniques. The patient is often ordered to submit to ordinary medical treatment when some hope of a cure or a significant prolongation of life exists. On the other hand, a person is not required to submit to extraordinary treatment that is not expected to cure or significantly ameliorate the underlying condition.<sup>57</sup> Given the degree of bodily intrusion, extraordinary treatment is considered a positive violation of the terminally ill individual's right to die with dignity.<sup>58</sup>

Recognizing that it is "obvious on reflection that cardiac or respiratory arrest will signal the arrival of death for the overwhelming majority of persons whose lives are terminated by illness or old age,"<sup>59</sup> the *Dinnerstein* court stated that *Saikewicz* should not be interpreted as requiring life-prolonging treatment absent a contrary court order.<sup>60</sup> It distinguished the earlier case and noted that *Saikewicz* involved ordinary medical treatment, while the prohibition of the "no-code" order on *Dinnerstein's* record would involve extraordinary treatment. The court noted the current medical ethics view that extraordinary means of prolonging life should not be employed where there is no hope of recovery.<sup>61</sup>

The *Dinnerstein* decision was important because it allowed the attending physician to make the "no-code" order decision without prior judicial approval.<sup>62</sup> The physician's decision would be subject to court review only if the doctor "has failed to exercise 'the degree of care and skill of the average qualified practitioner.'"<sup>63</sup>

#### D. *Custody of a Minor*

The "substituted judgment doctrine" applied in *Saikewicz* was expanded in another Massachusetts case, *Custody of a Minor*.<sup>64</sup> This case involved a newborn child with serious cardiac problems who had been abandoned at birth. Upon the petition of a social worker, a Boston juvenile court granted temporary legal custody of the child to the Department of Social Services (DSS) and appointed a guardian ad litem.<sup>65</sup> Doctors treating the baby asked the DSS and the guardian ad litem to consent to a "no-code" order; both parties refused. As a result, suit was filed in the juvenile court, and after a hearing, the judge entered the "no-code" order. After a series of stays and appeals, the juvenile court's decision was af-

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57. *Id.* at \_\_\_\_, 380 N.E.2d at 137-38.

58. *Id.* at \_\_\_\_, 380 N.E.2d at 139 n.10.

59. *Id.* at \_\_\_\_, 380 N.E.2d at 136.

60. *Id.* at \_\_\_\_, 380 N.E.2d at 137.

61. *Id.* at \_\_\_\_, 380 N.E.2d at 137 (citing Lewis, *Machine Medicine and Its Relation to the Fatally Ill*, 206 J. A.M.A. 387 (1968)).

62. 6 Mass. App. Ct. at \_\_\_\_, 380 N.E.2d at 139.

63. *Id.* (quoting *Brune v. Belinkoff*, 354 Mass. 102, 109, 235 N.E.2d 793, 798 (1968)).

64. 385 Mass. 697, 434 N.E.2d 601 (1982).

65. *Id.* at \_\_\_\_, 434 N.E.2d at 602.



firmed by the Massachusetts Supreme Judicial Court.<sup>66</sup> The court reasoned that because of the graveness of the cardiac problems the infant would, if competent, have chosen to forego extraordinary medical efforts in the event of cardiac or respiratory arrest.<sup>67</sup> The court stated that this was not a right-to-life issue, but rather, as in *Dinnerstein*, a question of "the manner of dying and what 'measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient's history and condition.'"<sup>68</sup>

## II. THE VIRGINIA NATURAL DEATH ACT

Against the background of the *Quinlan* and *Saikewicz* cases, and the research and drafting by the Joint Subcommittee Studying the Rights of the Terminally Ill,<sup>69</sup> the Virginia Natural Death Act was enacted by a narrow margin.<sup>70</sup> Since 1976, three similar bills had been introduced but defeated by the General Assembly.<sup>71</sup>

The objectives of the Act are twofold. First, it codifies the common law right of a competent adult to refuse extraordinary medical treatment. This is accomplished by a declaration which states that no extraordinary medical measures should be used if the declarant is ever afflicted with a terminal condition. Second, the Act allows certain family members, with the attending physician's consent, to make the treatment decision for a patient who is incompetent or otherwise unable to communicate his wishes.<sup>72</sup>

Three publicized meetings, two public hearings, and a number of written comments submitted by interested parties contributed to the development of the Act.<sup>73</sup> After considering this information, the Subcommittee indicated that its highest priority was protecting the rights of adult patients incapable of communicating their treatment decisions.<sup>74</sup> Although the Subcommittee was aware of the *Quinlan* and *Saikewicz* decisions, it thought that more structured guidelines were necessary, especially in defining the circumstances under which a third party, such as a

66. *Id.* at \_\_\_\_, 434 N.E.2d at 603-05.

67. *Id.* at \_\_\_\_, 434 N.E.2d at 605, 610.

68. *Id.* at \_\_\_\_, 434 N.E.2d at 609 (quoting *In re Dinnerstein*, 6 Mass. App. Ct. at \_\_\_\_, 380 N.E.2d at 134).

69. See *supra* note 15.

70. The bill passed the House of Delegates by a vote of 58 to 37. It then went to the Senate where it was passed, with amendments, by a 21 to 18 vote. The House agreed to the Senate amendments by a 59 to 37 vote, and finally the bill was sent to the Governor for review and approval. 1983 Va. Acts \_\_\_\_.

71. See H.B. 872, 1980 Virginia General Assembly; H.B. 1840, 1977 Virginia General Assembly; H.B. 620, 1976 Virginia General Assembly.

72. VA. CODE ANN. § 54-325.8:2 (Cum. Supp. 1983).

73. REPORT, *supra* note 15, at 5.

74. *Id.* at 10.

family member, may authorize or refuse treatment for the patient using a type of "substituted judgment" process.<sup>75</sup>

Significantly, the Subcommittee concluded that due to the lack of guidelines in Virginia, "the patient's family and the health care providers [are] reluctant to refuse or withdraw life-prolonging medical treatment. Thus, some terminally ill patients are being treated against their wishes and, increasingly, the courts are being called upon to make the treatment decision."<sup>76</sup> The Subcommittee also acknowledged the severe emotional and financial strain on the surviving family, since a patient's death does not always occur swiftly.<sup>77</sup> Various objections to the passage of the Act were raised before the Subcommittee,<sup>78</sup> and several issues remain unanswered.

#### A. *What Is A Terminal Condition?*<sup>79</sup>

The Act defines terminal condition as "a condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty, . . . there can be no recovery and . . . death is imminent."<sup>80</sup> The Subcommittee admitted its awareness of the problems inherent in this definition of terminal condition. It considered including a "specific time frame within which death would result," but later rejected such a determination.<sup>81</sup> The Subcommittee believed that the phrase "death is imminent" conveyed the intended meaning as precisely as possible.<sup>82</sup>

Nonetheless, concern was expressed to the Subcommittee that many terms used in the definition are ambiguous. The meaning of the phrase "reasonable degree of medical certainty" was questioned.<sup>83</sup> Another serious problem with the definition of terminal condition may lie in the meaning of "imminent," which could mean tomorrow, next week, six months from now, or next year.<sup>84</sup> A critic of the Act urged that "whether . . . life support is instituted or withdrawn *must* be determined by the imminence and *inevitability* of death and not by the imminence and

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75. *Id.*

76. *Id.*

77. *Id.* at 11.

78. *Id.* at 19-20.

79. *Id.* at 13.

80. VA. CODE ANN. § 54-325.8:2 (Cum. Supp. 1983).

81. REPORT, *supra* note 15, at 14.

82. *Id.*

83. Letter from Earl R. Johnson, Jr., M.D. to the Joint Subcommittee Studying the Rights of the Terminally Ill (Dec. 29, 1982) [hereinafter cited as Johnson].

84. Letter from Lena Harknett, Co-Chairman, Legislative Committee, Virginia Society for Human Life, to the Joint Subcommittee Studying the Rights of the Terminally Ill (Feb. 1, 1983) [hereinafter cited as Harknett (Feb. 1, 1983)]; *see also* Letter from Lena Harknett to the Subcommittee (Dec. 29, 1982) [hereinafter cited as Harknett (Dec. 29, 1982)].

*probability of death.*"<sup>85</sup>

The ambiguity in the definition of terminal condition has triggered fears that the Act practically allows doctors to practice euthanasia. Another critic expressed this fear, saying:

A definition of terminal illness that this bill initiates would encourage broader interpretation by bold sources in the medical community . . . . For example, a person with what is thought of as an incurable illness, such as diabetes, polio, mental retardation, senility, etc., could be regarded as "terminal" in time of accident or crisis, when artificial means would be necessary to prevent his "imminent death" and sustain him until the current problem is alleviated.<sup>86</sup>

These definitional problems are significant, and may create serious problems in the overall operation of the Act.

### B. *The Role of the Physician and Hospital Committees*

One of the Subcommittee's goals was to draft legislation that would adequately protect physicians and other health care providers from civil and criminal liability for withdrawing or withholding medical treatment under the Act.<sup>87</sup> The Subcommittee was aware that physicians fear the legal consequences of "accept[ing] [a] patient for the sole purpose of authorizing the removal of life-prolonging apparatus."<sup>88</sup> Thus, a provision was included in the Act immunizing physicians from civil and criminal liability for complying with the procedure as set forth.<sup>89</sup>

Critics were skeptical about the wisdom of allowing health care providers to be completely unanswerable for their conduct.<sup>90</sup> They complained that the Act leaves room for the unscrupulous or careless practice of medicine, since the physician's degree of legal responsibility toward the patient is diminished by the absolute immunity provision.<sup>91</sup> One physician pointed out that requiring a doctor, who refuses to comply with a declaration authorized by the Act, to make efforts to transfer his patient to another doctor would be unfair to those doctors "who will fight for the life of their patients as long as there is any chance of recovery . . . ."<sup>92</sup>

85. Johnson, *supra* note 83.

86. Letter from Geline B. Williams, Chairman of the Board of Directors, National Right to Life Committee, to the Joint Subcommittee Studying the Rights of the Terminally Ill (Feb. 1, 1983) [hereinafter cited as *Right to Life*].

87. REPORT, *supra* note 15, at 12.

88. *Id.* at 11.

89. VA. CODE ANN. § 54-325.8:8. (Cum. Supp. 1983).

90. Telephone interview with Geline B. Williams, Chairman of the Board of Directors, National Right to Life Committee (Apr. 11, 1983).

91. *Id.* See Johnson, *supra* note 83.

92. Johnson, *supra* note 83.

Such action is required by the Act.<sup>93</sup> Another commentator argued that “[i]nvariably, some patients will die who might have recovered.”<sup>94</sup>

A Medical College of Virginia professor recommended the use of an ethics committee very similar to the one in *Quinlan*.<sup>95</sup> He pointed out that the decision to withhold or withdraw treatment takes place most often in a hospital’s Intensive Care Unit (ICU),<sup>96</sup> and cautioned that doctors, especially those in teaching hospitals, “are frequently unaware of the patient other than as a challenge to the efficiency of the life support systems.”<sup>97</sup> According to the professor, these factors, coupled with the trend toward Health Maintenance Organizations and less personalized medical care in general, mean that the “assumption that humanistic or legalistic interactions will take place is totally false unless [the Act creates] a formalized structure that makes dialogue between those responsible for life withdrawal possible.”<sup>98</sup> His proposed solution to this potentially dehumanizing and dehumanizing situation was to create an ICU “Life Support Committee” to ensure informed consent for life support withdrawal.<sup>99</sup> This informational committee would meet regularly with the patient’s family to advise them of the patient’s condition.<sup>100</sup> Part of this proposed procedure includes written notification to the family that the patient has been diagnosed as terminally ill.<sup>101</sup>

Other commentators endorsed a hospital committee structure, primarily for the purpose of having more than one physician’s decision concerning a patient who has not made a prior declaration.<sup>102</sup> The committee would consist of two specialists in the appropriate area of medicine.<sup>103</sup> Legal and religious advice would also be provided to the next of kin, who would make the ultimate decision.<sup>104</sup> In principle, this type of committee effectuates what the Act proposes: that in order for an incompetent person without a declaration to become “qualified,” one other physician must concur with the attending physician that the patient is “afflicted

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93. VA. CODE ANN. § 54-325.8:7 (Cum. Supp. 1983).

94. Harknett (Dec. 29, 1983), *supra* note 84.

95. Letter from William Regelson, M.D., Professor of Medicine at the Medical College of Virginia, to the Joint Subcommittee Studying the Rights of the Terminally Ill (Dec. 28, 1982) [hereinafter cited as Regelson]. See *supra* text accompanying notes 37-38.

96. Regelson, *supra* note 95.

97. *Id.*

98. *Id.*

99. *Id.* Dr. Regelson proposed a committee composed of a hospital administrator, the attending physician, the ICU physician, an ICU nurse, and a lay representative, such as a chaplain or trustee. *Id.*

100. *Id.*

101. *Id.*

102. Harknett (Feb. 1, 1983), *supra* note 84.

103. *Id.*

104. *Id.*

with a terminal condition."<sup>105</sup>

The Act neither precludes nor requires these committees. Hence, the decision-making process remains strictly a private matter between the patient, the family, and the attending physicians.

### C. *Is the Act Necessary?*

Some commentators believed the Act was an unnecessary codification of current practices and procedures.<sup>106</sup> They argued that the Act does not add to the rights of incompetent patients because families have always had the right to consult another physician.<sup>107</sup> Critics also suggested that the Act authorized needless state intrusion into a private decision-making process.<sup>108</sup> They believed medical decisions about incompetent patients should be left to the immediate family following consultations with doctors and ministers.<sup>109</sup>

Despite these opinions, the Subcommittee determined that legislation was necessary to ensure the right of competent patients to refuse treatment and to resolve the uncertainty surrounding treatment of incompetent patients.<sup>110</sup>

### D. *Making and Revoking the Declaration*

The Act's major drawback may be its lack of adequate assurance for informed consent. This problem is inherent in a system of giving in-

105. VA. CODE ANN. § 54-325.8:2 (Cum. Supp. 1983).

106. See, e.g., Johnson, *supra* note 83. Dr. Johnson stated:

Physicians are already withholding or withdrawing life support from patients when fully convinced that death is both imminent and inevitable. In my 28 years of clinical experience I have never seen a patient with terminal cancer put on a respirator, nor have I ever seen a patient with a demonstrably dead brain maintained on a respirator longer than was required to make that determination and to obtain the consent of the patient's family to discontinue it . . . Furthermore, patients with fatal diseases . . . whose death is imminent and inevitable almost always have a "no-code" order on their charts.

*Id.* See also Right to Life, *supra* note 86.

107. Johnson, *supra* note 83.

108. Right to Life, *supra* note 86.

109. Letter from Kathleen E. Scheg, Associate Director, Office of Justice and Peace for the Catholic Diocese of Richmond, Virginia, representing Bishop Walter F. Sullivan, to the Joint Subcommittee Studying the Rights of the Terminally Ill (Feb. 1, 1983) (Petitions encouraging the General Assembly to enact legislation allowing a competent person to refuse medical treatment were attached to the letter.).

Since the Catholic Church's primary concerns — patient's rights and absolute prohibition of euthanasia — are addressed by the Act, the Church found it consistent with Catholic beliefs and teachings. *Id.* See also *In re Quinlan*, 70 N.J. 10, \_\_\_\_\_, 355 A.2d 647, 658 (1976) (quoting an address by Pope Pius XII to anesthesiologists on Nov. 24, 1957).

110. REPORT, *supra* note 15, at 11.

formed consent today for action to be taken under unknown circumstances in the future.<sup>111</sup> While a healthy person may freely consent to execute a declaration when he is well, his wishes may change when death is imminent.<sup>112</sup>

The Subcommittee addressed this potential problem, but only in the area of oral declarations.<sup>113</sup> In order to minimize the potential for falsification of an oral declaration, the Act requires that the declaration be made in the presence of a physician and two witnesses.<sup>114</sup> In addition, the oral declaration must be made subsequent to the diagnosis of a terminal condition.<sup>115</sup> The Subcommittee believed this would guarantee the "opportunity for a well-informed decision,"<sup>116</sup> since the decision would be made when the full extent of the illness is known.

The Act, however, fails to address adequately the competency or incompetency of the patient at the time of the declaration. The Act has been criticized for its "pervasive problems of competency and incompetency."<sup>117</sup> For example, the testimony of witnesses is the only means of determining a person's competency at the time a declaration is made; however, witnesses under the Act can be anyone "who is not a spouse or blood relative of the patient."<sup>118</sup> This implies that a minor, or a person with a financial interest in the declarant's death, could act as a witness. More stringent limitations were recommended.<sup>119</sup>

The Act also fails to provide a procedure for proving incompetency before the "substituted-decision" process is triggered. Under Virginia law, a patient's incompetence must be shown by clear and convincing evidence before a court can order a physician to administer life-saving treatment.<sup>120</sup> The Act, however, allows physicians and families to withhold life-saving treatment without any neutral adjudication of the patient's incompetence.<sup>121</sup> This also applies when the patient has made a previous declaration and later becomes incompetent. Critics have stressed the need for an impartial body, such as a court or hospital committee, to determine whether the patient is "irreversibly"<sup>122</sup> incompetent within the meaning

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111. Harknett (Feb. 1, 1984), *supra* note 84; Harknett (Dec. 29, 1982), *supra* note 84.

112. Johnson, *supra* note 83.

113. REPORT, *supra* note 15.

114. VA. CODE ANN. § 54-325.8:3 (Cum. Supp. 1983).

115. *Id.*

116. REPORT, *supra* note 15, at 13.

117. Testimony of Willis J. Spaulding, Director, Mental Health Law Training and Research Center, University of Virginia, to the Senate Committee on Education and Health (Feb. 17, 1983) [hereinafter cited as Spaulding].

118. VA. CODE ANN. § 54-325.8:2 (Cum. Supp. 1983).

119. Spaulding, *supra* note 117, at 3.

120. VA. CODE ANN. § 37.1-134.2 (Cum. Supp. 1982).

121. Spaulding, *supra* note 117, at 3.

122. *Id.* at 6-7.

of the Act. Even with the safeguard of an impartial decision-maker, an incompetent patient with a declaration on record may still be vulnerable<sup>123</sup> where he wants to revoke a prior declaration, but is unable to communicate this desire.<sup>124</sup>

Furthermore, a discrepancy exists between the language of the Act and the text of the suggested declaration form regarding the degree of certainty required for a diagnosis of "terminal condition."<sup>125</sup> The Act requires a terminal condition to be diagnosed to a "reasonable degree of medical certainty,"<sup>126</sup> while the declaration contains no such standard.<sup>127</sup> Taken as a whole, these factors point out the Act's shortcomings regarding informed consent from both competency and substantive information standpoints.

### E. *Substituted Consent to Withdrawal of Treatment*

In the absence of a declaration, family members must decide whether to terminate treatment for an incompetent patient. The Subcommittee recommended adoption of guidelines to aid family members in making this decision.<sup>128</sup> Accordingly, the Act outlines procedures to be followed, beginning with consultation and agreement between the attending physician and an individual family member specified in the Act.<sup>129</sup> To safeguard against fraud, the Act requires "at least two witnesses present at the time of the consultation when the treatment decision is made . . ." <sup>130</sup> Further, at least two of the persons allowed by the statute to make a "substituted judgment" must consent whenever possible.<sup>131</sup> The Subcommittee "contemplated that by mandating consultation and the priority of decision-makers, and providing for disinterested witnesses the decision will be made in the best interests of the patient."<sup>132</sup>

Unfortunately, many of the concerns expressed over competency and

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123. Harknett (Dec. 29, 1982), *supra* note 84.

124. A declaration may be revoked orally or by physical destruction of the written document. VA. CODE ANN. § 54-325.8:5 (Cum. Supp. 1983).

125. Johnson, *supra* note 83. See VA. CODE ANN. § 54-325.8:4 for a suggested form of written declaration.

126. VA. CODE ANN. § 54-325.8:2 (Cum. Supp. 1983).

127. *Id.* at § 54-325.8:4.

128. REPORT, *supra* note 15, at 17. Other states allow third parties to make treatment decisions on behalf of an incompetent patient. See ARK. STAT. ANN. § 82-3803 (Supp. 1983); DEL. CODE ANN. tit. 16 § 2502 (Cum. Supp. 1982); N.C. GEN. STAT. § 90-322 (Repl. Vol. 1981).

129. VA. CODE ANN. § 54-325.8:6 (Cum. Supp. 1983) (judicially appointed guardian or committee, persons designated by the patient in writing, patient's spouse, patient's adult child, patient's parents, patient's nearest living relative).

130. *Id.* See REPORT, *supra* note 15, at 13.

131. VA. CODE ANN. § 54-325.8:6 (Cum. Supp. 1983).

132. REPORT, *supra* note 15, at 18.

informed consent also apply to the "substituted judgment" procedures in the Act. The next of kin making the decision could have a financial interest by way of inheritance rights.<sup>133</sup> Additionally, the Act makes family members immune from civil and criminal liability for their actions.<sup>134</sup> This appears to leave the burden of detecting any bad faith upon the physician. Yet there is nothing the physician can do about it, given his obligation under the Act to transfer a patient to another doctor if he refuses to comply with the family's request.<sup>135</sup> Moreover, some have argued that the Act does not "advance the patient's 'fundamental right to control decisions' by summarily assigning that right to someone else."<sup>136</sup>

#### F. *The Pregnant or Minor Patient*

An interesting aspect of the Act involves its treatment of pregnant and minor patients. In light of the trimester rules of *Roe v. Wade*,<sup>137</sup> the legislature's failure to limit application of the Act to women in their first trimester of pregnancy leaves the Act open to potential invalidation on constitutional grounds.<sup>138</sup>

The existing legal rights of minors are preserved, but not expanded under the Act.<sup>139</sup> Some legislative protection already exists for minors in situations similar to those contemplated by the Act. Federal legislation indirectly protects all handicapped persons, including minors, from discrimination based on a handicap.<sup>140</sup> Louisiana is presently the only state

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133. Spaulding, *supra* note 117, at 3.

134. *Id.* at 4. See also VA. CODE ANN. § 54-325.8:8 (Cum. Supp. 1983).

135. VA. CODE ANN. § 54-325.8:7 (Cum. Supp. 1983).

136. Spaulding, *supra* note 117, at 4 (quoting H.B. 329, 1983 Va. Gen. Assem., *codified at* VA. CODE ANN. § 54-325.8:1 (Cum. Supp. 1983)).

137. 410 U.S. 113 (1973).

138. See VA. CODE ANN. § 54-325.8:2 (Cum. Supp. 1983) (defining "qualified patient" without special provision for pregnant patients).

Other statutes disqualify a pregnant woman during the term of her pregnancy. ALA. CODE § 22-8A-4(a) (Cum. Supp. 1982); CAL. HEALTH & SAFETY CODE § 7188 (West Cum. Supp. 1983); DEL. CODE ANN. tit. 16 § 2503(d) (Cum. Supp. 1982); KAN. STAT. ANN. § 65-28,103 (1982); NEV. REV. STAT. § 449.610 (1979 & Adv. Sheets 1983); TEX. REV. CIV. STAT. ANN. art. 4590(h) (Vernon Cum. Supp. 1982-83); WASH. REV. CODE ANN. § 70.122.030 (Cum. Supp. 1983-84).

139. VA. CODE ANN. § 54-325.8:12 (Cum. Supp. 1983).

140. See Rehabilitation Act of 1973, § 504 (codified as amended at 29 U.S.C. § 794 (1976 & Supp. 1982)). The government is currently attempting to promulgate even more stringent laws to protect infants from deliberate starvation. See Nondiscrimination on the Basis of Handicap, 48 Fed. Reg. 9630 (1983) (interim final rule) (invalidated by court order and suspended pending appeal, 48 Fed. Reg. 17,588 (1982)). For a discussion of the legal problems concerning "defective" infants, see W. WADDINGTON, C. WHITEBREAD & S. DAVIS, CHILDREN IN THE LEGAL SYSTEM 901 n.1 (1983). Two states include specific provisions for minors in natural death legislation. ARK. STAT. ANN. § 82-3804 (Cum. Supp. 1983); N.M. STAT. ANN. § 24-7-4 (Repl. Vol. 1981).



with a law forbidding the deprivation of food, water, oxygen, or medical care necessary to preserve the life of an infant,<sup>141</sup> even where the quality of life will be diminished if the child lives.<sup>142</sup> That statute contains an exception, however, which is triggered when the child is in a profound comatose condition.<sup>143</sup> The constitutionality of this exception has been upheld in the Louisiana Supreme Court.<sup>144</sup>

The Subcommittee felt that the right to make a declaration should be reserved for competent adults<sup>145</sup> "due to the much stronger interests of the parents or guardians and the state in [the minor's] treatment decisions."<sup>146</sup> The complexity of these issues, as well as time limitations,<sup>147</sup> led the Subcommittee to recommend further study of treatment decisions for terminally ill minors.<sup>148</sup> The Subcommittee also recognized that "judicial determination of [these issues] might be appropriate . . ."<sup>149</sup>

### III. CONCLUSION

At first impression, the Virginia Natural Death Act merely appears to codify rights and procedures in existence at common law or in common practice by physicians. The Act is useful because it sets forth procedures for physicians and families to follow. However, ethical issues arise for virtually all persons complying with the Act. Physicians now must face the task of judging when to save lives, as well as how to comply with the statute. Additionally, they may be discouraged from pursuing vigorous treatment of a patient due to fear of liability for failure to comply with the Act.

Another concern raised by the Act is that patients may feel compelled to sign a declaration because of the escalating cost of medical care in light of the financial burden extended care creates. In addition, the Act may induce feelings of worthlessness in elderly persons.

There is throughout the proposed act . . . the implied notion that a terminally ill person who *does* want extraordinary means used is engaged in a somewhat demeaning action that causes loss of dignity and gives him only a

141. LA. REV. STAT. ANN. § 40:1299.36.1(A) (West Cum. Supp. 1983).

142. *Id.* § 40:1299.36.1(B).

143. *Id.* § 40:1299.36.1(C).

144. *In re P.V.W.*, 424 So. 2d 1015 (La. 1982) ("No-code" order on brain-damaged infant). The Massachusetts Supreme Judicial Court accomplished the same result without a statute. *See Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982). *See also* Application of Cicero, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Sup. Ct. 1979) (child "defective" but not brain dead).

145. REPORT, *supra* note 15, at 16.

146. *Id.*

147. *Id.*

148. *Id.*

149. *Id.* at 17.

precarious and burdensome existence. The act can be read by the elderly and/or seriously ill as a subtle document of self-rejection. The elderly are encouraged to fashion an image of themselves as not being useful or as being a burden on the rest of society . . . .<sup>150</sup>

Finally, the philosophical and moral implications of such legislation are significant. Critics fear that the Act brings the State one step closer to condoning euthanasia.

Whether the Act is necessary, or whether it adds to the existing rights of competent and incompetent patients is debatable. It was probably more appropriate for the legislature to speak on the subject than for the Virginia courts to be forced to judicially legislate in this area. By making the termination procedure easy for the surviving family, the Act may have neglected to protect the vulnerable patient. The balance between preserving a patient's privacy and providing safeguards to prevent abuse is delicate. The Act, as it now stands, preserves privacy at the expense of adequate safeguards. Many issues remain to be addressed before the Virginia Natural Death Act will truly ensure death with dignity.

*Janice G. Murphy\**

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150. Harknett (Dec. 29, 1982), *supra* note 84 (emphasis added).

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