REPORT OF THE

JOINT SUBCOMMITTEE STUDYING THE

RIGHTS OF THE TERMINALLY ILL

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 32

COMMONWEALTH OF VIRGINIA
RICHMOND
1983

MEMBERS OF COMMITTEE

Bernard S. Cohen, Chairman
David G. Brickley
A. Joseph Canada, Jr.
J. Samuel Glasscock
Frederick T. Gray
John W. Hoyt, M.D.
Robison B. James
The Right Reverend David H. Lewis, Jr.
Susan J. Mellette, M.D.
Theodore V. Morrison, Jr.
Frank W. Nolen
Nicholas A. Spinella, Esquire
R. R. Young, Jr., Esquire

STAFF

Legal and Research

Mary P. Devine, Esquire
Mary K. Geisen, Legal Assistant

Administrative and Clerical

Office of Clerk, House of Delegates

Barbara Hanback

TABLE OF CONTENTS

Report of the
Joint Subcommittee Studying the Rights
of the Terminally Ill
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
December, 1982

To: Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

INTRODUCTION

House Joint Resolution 115 (Appendix A) was passed by the 1982 Session of the General Assembly in recognition of the increasing public concern over the care and treatment of terminally ill persons. The resolution created a joint subcommittee to study the complex legal, medical and moral issues in cases involving the termination or refusal of life-prolonging medical treatment. The membership of the subcommittee was designed to reflect these varied interests and provide a cross-section of persons familiar with the problems.

Delegates Brickley, Cohen and James were appointed from the House Committee on Health, Welfare and Institutions; Delegates Glasscock (of Suffolk) and Morrison were appointed from the House Committee for Courts of Justice; Senators Gray and Nolen were appointed from the Senate Committee on Education and Health; and Senator Canada was appointed from the Senate Committee on Rehabilitation and Social Services. In addition, five citizen members were appointed to represent the legal and medical professions and the clergy. The citizen members were: Dr. John W. Hoyt, Medical Director of the Intensive Care Unit at the University of Virginia Medical Center; the Right Reverend David H. Lewis, Jr., Suffragan Bishop of the Episcopal Diocese of Virginia; Dr. Susan J. Mellette of the Medical College of Virginia; Nicholas A. Spinella, Esquire, of Richmond; and R. R. Young, Jr., Esquire, of Martinsville.

The subcommittee held three well-publicized meetings and two formal public hearings in Richmond in an attempt to maximize public input. All the meetings were well attended. Members of the public were given an opportunity to address the subcommittee at each meeting. In addition, the subcommittee solicited written comments from interested persons regarding the work of the subcommittee and the numerous drafts of legislation considered by the subcommittee. During the course of the study the subcommittee drew on the expertise of the members and the input received from those concerned citizens and groups. Among those providing information for the subcommittee were: the Medical Society of Virginia; William H. Regelson, M.D., Professor of Medicine, MCV; A. Patrick L. Prest, Jr., D.D.; Read F. McGhee, M.D.; Willis J. Spaulding, Director of the Mental Health Law and Training Center; the Most Reverend Thomas J. Welsh, Roman Catholic Bishop of Arlington; the Virginia Nurses Association; the Virginia Conference of the United Methodist Church; the Virginia Society for Human Life; the Virginia Council of Churches; and the Society for the Right to Die. (See Appendix B for written statements submitted.)

EXECUTIVE SUMMARY

Following a comprehensive study of the problems associated with medical care decisions for the terminally ill, the subcommittee makes the following recommendations:

1. That the right of all competent adults to consent to or refuse medical treatment be recognized;

2. That competent adults be allowed to exercise this right by documenting their wishes prior to the time a treatment decision must be made;

3. That procedures be provided for refusing and discontinuing life-prolonging treatment, especially in regard to terminally ill persons who are incapable of communicating their wishes at the time a treatment decision is made but have previously expressed their wishes

in a verifiable manner;

4. That persons participating in the decision to withhold or withdraw life-prolonging medical treatment from a terminally ill patient be granted immunity to ensure that the patient's wishes are carried out;

5. That penalties be imposed upon persons who falsify, forge or conceal a patient's declaration, or its revocation, thereby causing the patient to be treated or not, contrary to his wishes.

BACKGROUND

The common law has long recognized the right of every individual to the possession and control of his person. Competent adults have the right to refuse medical treatment. In certain circumstances, however, the right of bodily self-determination must yield to an exercise by the state of its authority to promulgate and enforce standards for the health and welfare of the citizenry, including standards for the preservation of life and protection of the integrity of the medical profession. The potential for conflict between the rights and interests of the individual and the state has long been present.

In recent years the potential conflict has become a matter of some concern to the citizens of the Commonwealth. Due to rapid technological advances in the field of medicine, it has become possible to keep a person artificially alive for an indeterminate period of time. While life may continue, the quality of the life is poor.

Public attention and concern have focused on the issues surrounding the use of artificial life supports since the New Jersey Supreme Court granted Karen Quinlan's father the authority to discontinue life-supporting treatment for his daughter. See, In re Quinlan , 70 N.J.10 (1976). A number of other courts have since addressed similar issues and reached differing conclusions. See e.g., In re Eichner and In re Storar , 52 N.Y.2d 363 (1981); In re Spring , 405 N.E.2d 115 (Mass., 1980); Satz v. Perlmutter 362 So.2d 160 aff'd 379 S.2d 359 (Fla., 1980); Severns v. Wilmington Medical Center , 421 A.2d 1334 (Del., 1980); and Superintendent of Belchertown State School v. Saikewicz , 373 Mass. 728 (1977).

Since 1976, three bills designed to define the rights and liabilities of persons involved in life or death decisions for the terminally ill patient have been introduced in the General Assembly. They are: House Bill 620 (1976), House Bill 1840 (1977) and House Bill 872 (1980). Thirteen states and the District of Columbia have enacted "Right to Die" or "Natural Death" legislation to date.

CONSIDERATIONS AND FINDINGS

The joint subcommittee focused its deliberations on the following issues: (i) whether there is a need for legislation to define the rights and liabilities of persons involved in medical care decisions for the terminally ill; and (ii) if legislation is needed, what provisions would be required to ensure that the patient's wishes are carried out and the exercise of the right to determine personal medical care does not impose unfair burdens, legally, morally, and adminstratively, upon health care providers, family members and others involved in the treatment decision.

A. Need For Legislation

The right of a competent adult patient to refuse medical treatment or order the removal of life-supporting apparatus has long been recognized by the common law. Except in certain limited circumstances, unconsented-to medical treatment constitutes a battery under the common law. The subcommittee believed this cause of action would ensure recognition of a competent adult's right to refuse treatment. However, the subcommittee noted with some concern a recent opinion of Judge Grenadier of the Circuit Court of Alexandria (Appendix C). The primary issue in the case was the patient's competence to refuse life-prolonging medical treatment. Although the patient was found to be competent, Judge Grenadier, citing the lack of policy and procedural guidelines provided by the Virginia Supreme Court or the General Assembly, found it necessary to address a secondary issue regarding the competent patient's right to refuse or discontinue treatment. Relying on the rationale of Saikewicz and Perlmutter , supra , Judge Grenadier held that a terminally ill competent adult may exercise his right of privacy by ordering the discontinuance of life-prolonging procedures. The

committee agreed with this holding but was concerned that the right of a competent adult to use life-prolonging medical treatment might be jeopardized because of the lack of legislative or judicial guidelines. The subcommittee noted that a number of state courts in other jurisdictions when called upon to decide similar cases, have specifically requested legislative guidance. See e.g., Satz v. Perlmutter (Fla.), In re Eichner (N.Y.) and In re Severns (Del.), supra .

The subcommittee was most concerned with life-prolonging treatment decisions involving an adult patient who is not physically or mentally able to express his wishes at the time of the treatment decision. This type of case is not covered by the common law. There are no reported Virginia Supreme Court cases or statutes governing this situation. It is unclear whether a close family member or other third party may authorize or refuse medical treatment on behalf of such a patient. Furthermore, the effect of a patient's so-called "Living Will" in a situation where the patient is incapable of participating in the treatment decision is unclear.

There is no law in Virginia prohibiting a person from executing such a document in advance, nor is there any provision of law either prohibiting or requiring compliance by a health care provider. However, because there are no laws providing guidance as to when a previously executed expression of intent is effective or when compliance would be justified, the patient's family and the health care providers are often 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.

The subcommittee heard testimony from various persons detailing their experiences under the current state of the law. In some cases the physician and family of the patient were able to reach and implement a decision as to the provision or withdrawal of life-prolonging treatment. In others, a decision could not be reached. One illustrative case which the subcommittee considered involved a woman who sought to have life-prolonging apparatus removed from her terminally ill husband. She had discussed this eventuality with her husband before he became comatose. He stated that he did not wish to be maintained on life-prolonging apparatus if there was no reasonable chance of recovery. Nonetheless, the treating physician would not withdraw the apparatus. Attempts to transfer the patient to a physician who would comply were unsuccessful. Other physicians feared criminal prosecution or civil liability if they were to accept the patient for the sole purpose of authorizing the removal of life-prolonging apparatus. No other treatment was necessary. Although the patient died within a few weeks, those weeks were emotionally and financially devastating for the woman. She had to sell her home in order to pay the medical expenses incurred during those weeks. The subcommittee agreed that if the patient had been able to communicate his wishes to the physician at the time the treatment decision was made, he would have been within his rights in authorizing the withdrawal of the apparatus.

The subcommittee concluded that legislation was necessary to assure recognition of a competent adult's right to determine his own medical care and to ensure that the rights of incompetent adult patients were protected to the same extent as the rights of competent adult patients under the common law. In order to accomplish these goals, the subcommittee agreed that the legislation should specifically recognize the common law right of bodily self-determination and provide definite, but simple, procedural guidelines for making a prior declaration of intent. Additionally, the subcommittee recognized the need to provide immunity from criminal prosecution and civil liability for those who make the treatment decision on behalf of the patient and those who implement the decision.

B. Summary of Proposed Legislation

The legislation proposed by the subcommittee (Appendix D) defines the rights and liabilities of those persons participating in health care decisons involving medical treatment which artificially prolongs the life of a terminally ill adult. The legislation codifies the right of all competent adults to determine their own medical care. Additionally, a patient who is unable to express his wishes at the time of the treatment is granted the authority to participate in the decision by previously documenting his wishes. The legislation contemplates a reasoned decision, made in advance, upon consultation with those persons most directly affected. It provides a simple mechanism for all such persons to make those decisions orally or in writing, before or at the time the treatment becomes necessary.

The subcommittee had the most difficulty with the definitional section of the legislation. The language had to be precise, yet easy to understand. The definition of a "declaration" incorporates by

reference the formalities for making a declaration. The subcommittee agreed that the procedure for making a declaration should be simple but that safeguards were required against fraudulent use of a declaration to facilitate or encourage the patient's death. Therefore, the legislation requires that the declaration be witnessed and, if written, signed by the declarant. The statutory form for a written declaration is provided only for convenience. It is not a required form. The subcommittee recognized that the potential for falsification of an oral declaration was much greater. Therefore, an oral declaration must be made in the presence of a physician and two witnesses. Additionally, the subcommittee believed that some protection was necessary to ensure that a casual remark made under vastly different circumstances did not form the basis for the withholding or withdrawal of life-prolonging medical treatment. Therefore, the legislation requires that an oral declaration must be made subsequent to the diagnosis of terminal illness. This provision assures the patient an opportunity for a well-informed decision.

The definitions of "life-prolonging procedure" and "terminal condition" were the most difficult to formulate. These definitions provide the major substance of the legislation. After many lengthy and often very technical discussions, the subcommittee decided that these definitions should be kept simple. The definition of "life-prolonging procedure" contemplates any medical intervention which artificially supports a natural bodily function which is necessary to sustain life. Such intervention merely prolongs the dying process for a patient in a terminal condition but offers nothing in the form of a cure for the illness. The definition of "terminal condition" is based in part on the definition given to that term in the statutes enacted in other jurisdictions. The definition contemplates a patient with no reasonable chance of recovery from a condition which a physician determines would naturally and inevitably cause the patient's death. In such a case, where the use of extraordinary, life-prolonging procedures would merely artificially prolong life and temporarily postpone the natural dying process, the patient's right to refuse such treatment should be recognized. The subcommittee discussed at great length the problems associated with determining when death will occur as the result of the terminal condition. A specific time period within which death would result was rejected. The subcommittee believed that the phrase "death is imminent" conveyed their meaning as precisely as possible.

Under the provisions of the legislation, if a patient (i) has made a declaration, (ii) is diagnosed to be in a terminal condition and (iii) cannot communicate his wishes, the declaration, whether oral or written, controls the treatment decision. The subcommittee believed the patient or someone acting on his behalf should have the duty to notify the attending physician of the existence of a declaration or revocation. Other jurisdictions have imposed a duty on the physician to ascertain whether a declaration was made. The subcommittee did not believe this was the proper approach.

In order to protect those who make or implement the treatment decision for a patient in a terminal condition, the subcommittee agreed that some type of immunity must be granted. The subcommittee found that a number of health care providers had become wary of making treatment decisions involving the withdrawal of life-prolonging medical treatment because of their fear of liability. Therefore, immunity from prosecution and civil liability was believed necessary to ensure recognition of the patient's rights. As long as a health care provider acts in good faith reliance on his belief that his actions are consistent with the patient's wishes, the immunity attaches. By providing immunity, the subcommittee sought to ensure implementation of their findings as outlined in the policy statement.

In other jurisdictions the policy implementation was accomplished by imposing sanctions on a physician who cannot or will not comply with the declaration. A majority of the subcommittee did not believe this was the proper approach. The members conceded a physician who failed to comply could effectively deprive the patient of the exercise of his right to refuse treatment. However, the subcommittee believed the immunity granted would implement the policy without placing undue burdens on the health care provider. The subcommittee agreed to impose a duty on a physician who refused to comply with a patient's declaration to make a "reasonable effort" to transfer the patient.

The subcommittee decided that penalties should be included for the forgery, concealment, destruction or falsification of a declaration or the revocation of a declaration. This provision was felt to be a necessary complement to the policy statement. The legislation is designed to afford a person the opportunity to exercise his right to participate in his medical treatment decisions in a manner which will not encourage euthanasia or mercy killing. By providing penalties for depriving the patient of his rights or unlawfully facilitating his death, this provision strongly implements the policy statement.

After a great deal of discussion and deliberation the subcommittee agreed that the authority to make a declaration should be limited to competent adults who seek to determine their own medical treatment. The subcommittee recognized the complex problems involved in treatment decisions for terminally ill minors and incompetents. It was agreed that the rights of these patients must be dealt with in a different manner due to the much stronger interests of the parents or guardians and the state in these types of treatment decisions. The subcommittee did not have the time to give this aspect of the issues under study adequate consideration. Additionally, the subcommittee did not want to delay reporting the recommendations for adults. The general feeling of the subcommittee was that a thorough study of the issues involved in treatment decisions for terminally ill minors and incompetents would be appropriate. It was suggested that experience under the proposed Natural Death Act would be helpful to such a study. Because of the state's strong interest in protecting those who are under a legal disability, the subcommittee recognized that judicial determination of the treatment issue might be appropriate in these cases. The subcommittee decided that a statement in the legislation preserving existing rights for these patients was desirable at this time.

The subcommittee believed the proposed legislation should specifically address those situations where an adult patient is not physically or mentally capable of participating in the treatment decision and has not previously made an oral or written declaration while competent. The subcommittee agreed that no presumption should arise regarding the patient's intent in such a situation. Additionally, the subcommittee agreed certain third parties having a special relationship with the patient should be granted the authority, upon consultation with the attending physician, to make the treatment decision if the patient is unable and has not previously documented his wishes. This provision is designed to remove the uncertainty regarding the rights and liabilities of persons involved in this type of decision. The subcommittee recognized that without this provision, the treatment decision could easily become a subject for judicial resolution. This has been the result in other states. (See e.g., In re Eichner, supra .) The subcommittee believed these types of decisions were best made within the patient-physician-family relationship rather than in a protracted judicial hearing.

Considerable discussion was held regarding the priority of third party decision-makers in the event the patient had not made a declaration (See § 54-325.8:6 of Appendix D). Specifically, the subcommittee was concerned that the legislation not be construed to require the judicial appointment of a guardian or committee. However, the subcommittee unanimously agreed that where one had previously been appointed, the guardian or committee was the proper person to make the decision. As a practical matter, the subcommittee believed that the guardian or committee would discuss the treatment decision with close family members, if available. It is 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.

CONCLUSION

After a thorough study of the legal, medical and moral issues involved in treatment decisions for the terminally ill the subcomittee strongly recommends adoption of the proposed legislation. The subcommittee found that there was a need for legislation to clarify the law in the Commonwealth regarding the rights and liabilities of persons participating in these decisions. The subcommittee believes the proposed legislation ensures recognition of a competent adult's right to bodily self-determination and provides a simple legal mechanism for the prior exercise of this right with proper safeguards to protect the sanctity of life.

INDEX TO APPENDICES

APPENDIX A

1982 REGULAR SESSION

LD4086462

HOUSE JOINT RESOLUTION NO. 115

Offered February 1, 1982

Establishing a joint subcommittee to study the rights of the terminally ill, the family and the medical profession in cases involving decisions of life and death.

Patrons–Giesen, Stafford, Hull, Miller, K. G., Slayton, and McClanan

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Referred to the Committee on Rules

WHEREAS, advances in medical technology have produced means by which many terminally ill patients can be kept alive by the use of life-sustaining equipment long after the hope of any recovery has been extinguished by competent medical authority; and

WHEREAS, every citizen of the Commonwealth has a right to demand a respect for the quality of his own life and to maintain a sense of dignity expressed outwardly to mankind regardless of the condition of his health; and

WHEREAS, persons who are terminally ill, in expressing these rights of human dignity, should have the right to object to extraordinary means of preserving life after hope of any recovery has vanished and to relieve family members of the anguish and, in many cases, crushing financial burdens incurred as a result of the use of extraordinary means to preserve the life of a terminally ill patient; and

WHEREAS, many physicians of the Commonwealth, because of their oath to perse life by utilizing the utmost and most extraordinary means possible, are placed in a burdensome moral dilemma, torn between the terminally ill patient's wish to die with dignity and feelings of worth, and the ability to keep such a patient clinically alive indefinitely by use of artificial-support devices; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That there is established a joint subcommittee to study the rights of the terminally ill, the family and the medical profession in cases involving decisions on life and death of the patient. The subcommittee shall consist of fourteen members. Four members shall be appointed by the Chairman of the House Committee on Health, Welfare and Institutions from the membership thereof. Two members shall be appointed by the Chairman of the House Committee on Courts of Justice from the membership thereof. Two members shall be appointed by the Chairman of the Senate Committee on Education and Health from the membership thereof. One member shall be appointed by the Chairman of the Senate Committee on Rehabilitation and Social Services from the membership thereof. Five citizen members shall be appointed by the Speaker of the House of Delegates and the Chairman of the Privileges and Elections Committee of the Senate. Of the five citizen members, two shall be members of the medical profession, two shall be members of the legal profession, and one shall be a member of the clergy.

The subcommittee shall complete its study in time to submit recommendations to 1983 Session of the General Assembly.

The cost of this study shall not exceed $7,700.

APPENDIX B1

JOINT LEGISLATIVE COMMITTEE MEETING
November 11, 1982

Ladies and Gentlemen:

I would be here personally but a long-term commitment necessitates my being out of town. I supported this resolution that made this committee possible in the last General Assembly and now wish to support your work with this testimony.

My concern for the seriously ill person is a matter of record. I have written extensively and lectured widely on the subject. My resume is attached and you may check my credentials.

Historically, theology, law, and medicine have lived in creative tension with each other albeit at times unhappy companions. This tension is intended for the well-being and protection of the citizens of any jurisdiction. No one profession is any more important than the other. The intention is that checks and balances are provided in our society so that the individual's rights are protected from either unreasonable authority or laissez-faire anarchism.

The documentation of the needs to protect the terminally ill and their rights will come from countless individuals. I will not add to that list though, of course, clinically I could give numerous cases including that of my own mother. Suffice it to say there is a need-otherwise this committee would not exist.

My hope is you will, in your corporate wisdom, come up with specific legislation to address the problem. Such legislation should bear in

mind primarily the rights of the sick person - not the professional needs of the caregiver.

The physician in the broadest sense has the best interests of the patient at heart. This may or may not include allowing the patient to die a natural death when the quality of life is no longer apparent. Some physicians cannot let nature take its course. They see themselves as healers, as life prolongers, and as responsible for keeping the bodily machine functioning. Their interpretation of the Hippocratic Oath is to do all that they can as long as there is breath. A concommitant fear is the accusation (and potential law suit) that they had not done all in their power to preserve life. The potentiality of some eager lawyer leading the charge on a mal-practice suit looms large as a realistic fear in our society. The medical profession detests the legal profession - and often vice-versa - though, of course, there are personal friendships across the boundary. This mutual distrust and hostility may include my own profession of the ministry as well. The fact that we do not get along, are often in combat, and manipulate each other to our own advantage should not detract from our mutual and corporate responsibility for others in our society. Just as Congress, the Executive and the Judicial branches of federal government are constantly offering checks and balances for society at large, so, too, should our three professions provide checks and balances for those who are unable to assert themselves. The theological profession is split right down the middle on the issue of the terminally ill. The medical profession is equally split - often saying one thing about doctor-patient relationships and yet professionally functioning in insensitive ways with patients i.e. keeping the patient

live beyond any reasonable hope for a decent life. The time has come or the legal profession (and the enactment of laws) to offer a clear, sensitive and compassionate witness to those less advantaged.

Virginia can be proud of its tradition to offer visionary and courageous legislation in the health-care field. This committee has an opportunity to make another significant contribution. Not one member of this committee envisions a prolonged, protracted and helpless death as a result of a stroke or malignancy. Every healthy person I know plans to die with their "boots on" in a blaze of glory - short and sweet - quick and decisive - though, of course, with their house in order.

Just as the Uniform Donor Card carries very specific legal instructions so, too, a Uniform Death Card could return to the individual his or her rights not to receive heroic treatment above and beyond what is reasonable. Obviously, a certain amount of discretion must be used by 1, 2 or 3 physicians in that determination. The most crucial need at this time is the deliberate and overt protection of the physician(s) from litigation. Only with this protection is the physician truly free to exercise his profession bearing in mind the previously expressed concerns of the patient.

I would recommend:

1) Uniform Death Card - to be included on the Uniform Donor Card on the driver's license.
2) Rigid protection for the physician(s) from litigation.
3) Rigid protection to family members who support the patient

from litigation by other family members.

4) Powerful affirmation of the right of the patient to define services rendered - with penalties attached to those persons who do not comply with the patient's expressed desire.

5) Affirmation of the rights of the patient with removal of all references to suicide and its legal implications.

6) Support of the importance of pre-formed judgement as a conscious, deliberate and intentional act that is respected by society and the medical profession.

7) Appropriate changes in all the laws with reference to the implications contained in this law.

In this way, a clear, clean and strong law may speak to those persons who are often completely unable to speak for themselves - or if ill, unable to be strong enough to demand their rights. As a compassionate society we can speak for them, offer them strength in their weakness and see to it that their rights and intentions are carried out. Prolonging life is no longer a goal: it has become an awesome responsibility. As sensitive, intelligent persons, we must now seek definitions of life that set realistic limits on the pain and suffering which must be born by the terminally ill. With your help we can accomplish the goal.

Respectfully submitted,

A. Patrick L. Prest Jr

The Rev. A. Patrick L. Prest, Jr.,

APPENDIX B2

BOARD OF GLOBAL MINISTRIES
VIRGINIA CONFERENCE
THE UNITED METHODIST CHURCH

Reference: House Joint Resolution No. 115

Subject: Establishing a joint subcommittee to study the rights of the terminally ill, the family, and the medical professionin cases involving decisions of life and death.

To: The Committee established by House Joint Resolution No. 115

1. The Health and Welfare Division of the Board of Global Ministries of the Virginia Conference of the United Methodist Church favors the establishment of a joint subcommittee to study the subject.

2. The Health and Welfare Division offers the following input for Consideration of the Subcommittee.

   a. The Division's Concurrence with the four (4) Whereases of the Resolution, and in addition there to:

      1. In cases where the patient is mentally and physically competent to make a decision, that individual's right to make the decision be respected to include any prior written statement by the individual.

      2. In cases where a power of attorney or guardian exists carrying authority to make decisions for the individual, that responsibility be exercised by the person holding that power of attorney.

      3. In cases where the patient is <u>not</u> mentally and physically competent to make a decision, and no written statement exists, that a concensus of responsible relatives have the responsibility for the decision.

      4. Due to the Hypocratic Oath taken by doctors and the possibility of conflict of interests, that doctors be relieved of other than advisory involvement.

Jeremy D. Galloway
Chairman, Health and Welfare Division

APPENDIX B3

VIRGINIA SOCIETY FOR HUMAN LIFE

VSHL

11 November 1982

STUDY COMMITTEE CONCERNING THE RIGHTS OF THE TERMINALLY ILL

Good morning Mr. Chairman and members of the committee. My name is Marjorie Higgins and I represent the Virginia Society for Human Life, a statewide pro-life organization concerned about the protection of innocent human life.

I am here to address various aspects in the rights of the terminally ill, one of which is more in line with what you are expecting and the other at the suggestion of Secretary Joseph Fisher and Chairman Cohen.

This past summer a case of infanticide, the deliberate killing of an infant took place in Indiana. An otherwise healthy baby was born with a congenital throat blockage which could have been corrected by ordinary surgery. The parents, the physicians, and the courts of Indiana denied basic medical help to a newborn infant who then died from starvation. You see that baby was diagnosed as having Downs Syndrome. Had he not had Downs Syndrome, the ordinary surgery would have been standard treatment. But he was less than perfect, unable to give consent and was incompetent under the law. Downs Syndrome is not a terminal disease but lack of food leading to starvation is terminal.

AFFILIATED CHAPTERS
[illegible] BLACKSBURG [illegible] FRANKLIN COUNTY P.O. Box 53 Ferrum 24088 [illegible] FREDERICKSBURG P.O. Box 1333 [illegible]
[illegible] PENINSULA P.O. Box 1333 Hampton [illegible]
[illegible] ROANOKE P.O. Box 4321 [illegible]

There does not seem to be any provision in Virginia law to protect against such an incident from occurring in Virginia. Friends of mine who have handicapped children have pointed out that in their knowledge and experience, letting handicapped infants die by deliberate neglect is so common that the Indiana situation is simply, "it's just becoming visible."

Realities, attitudes, and perceptions are the intangibles you as the study committee must also wrestle with.

We sympathize with the real and difficult problems encountered by patients, their families, physicians, and the facilities involved in caring for those who are dying. We also acknowledge isolated cases of abuse in maintaining patients artificially beyond reasonable hope and causing undue suffering and grief. But the norm is not that dramatic illustration of a doctor callously keeping a patient on expensive machines over the protests of both patient and family.

Legislation, which is by nature inflexible cannot deal with the increasing options of technological means of medical care.

Treatment for a terminally ill person, someone who is dying falls within the domain of caring rather than curing. Virginia, years ago, deferred passage of Death with Dignity legislation to study the concept of Hospice as a more positive way to care for the dying. Virginia has since passed enabling legislation for Hospice. In my own neighborhood in Richmond, Retreat Hospital has a Hospice unit. St. Mary's Catholic Hospital will have one in January of 1983. Other areas of the state are considering Hospice units.

Various states have prematurely passed what I call Death Criteria laws but there are also states which have defeated such laws, most recently Connecticut, the pioneer in the field of Hospice.

Virginia's experience with Hospice is still fledgling. Let's give that concept of caring for the dying the opportunity to influence our attitudes without insisting on Death Criteria legislation. Introducing Death Criteria legislation would only serve to ~~accentuate~~ create the perception ~~that those with power have an obsession with death rather than a concern for enhancing health.~~ that death is the primary goal rather than caring for the patient's life.

There are and will continue to be real problems in treating those who are dying. But no law can alleviate the complexity of the human relations involved which make those situations so emotionally trying for everyone involved.

Death is so final that for society's own protection we should insist on care and not upon criteria.

Marjorie D. Higgins
2015 Stuart Avenue
Richmond, Virginia 23220
(804) 358-5738

MEDICAL COLLEGE OF VIRGINIA
VIRGINIA COMMONWEALTH UNIVERSITY
MCV Station • Richmond, Virginia 23298

December 28, 1982

Mr. Bernard S. Cohen
Chairman
Joint Subcommittee Studying
the Rights of the Terminally Ill
General Assembly Building
910 Capital Street
Richmond, Virginia 23208

Dear Mr. Cohen and Members of the Joint Committee:

I feel that the bill that you and your committee have assembled misses the real issue which is "informed consent for the terminally ill". This issue, most often, takes place in a very special environment, i.e., intensive care units; where, increasingly, decision making in regard to the termination of life support is made.

As I discussed at your committee hearing, we have developed, in ICU's, special technology that is equipped to maintain life at increasing cost and effort and it is in these special environments that the real problem of life termination exists. As technology improves the number, surviving on machines will increase.

What is missing from the act is definition of the mechanism of responsibility for creating "the judicially appointed guardian or committee of the person or the patient". What structure seeks to find the person designated by the patient in his declaration? Who is to notify and to act in a defined manner to inform the patient's spouse, parent or nearest living relative? Who sets up the decision making structure for those without "living wills"?

What is the character of witnesses at the consultation at the time of the life withdrawal decision? Will any witness do? Don't you want trained witnesses who are familiar with medical practice and the evaluation of the quality of survival for the patient?

I am sorry, but I do not think "living wills" will solve the problem and will create a "field day" for lawyers.

I feel the law has to take into account the need for a formal hospital structure to interact with those that make the decision. Again, almost all decision making regarding withdrawal of life support takes place in a hospital environment.

I feel your legislation misses the issue because those on your legislative subcommittee have as their personal physicians involved doctors operating at a level of contractual, professional and humanistic

concern. Unfortunately, this is not the case in many teaching hospitals and is particularly a problem with the increasing bureaucratization of patient care in intensive care or major support facilities. In these facilities, the physicians in charge are frequently unaware of the patient other than as a challenge to the efficiency of the life support systems.

I feel the bill does not take into account the changing character of medical practice: This pattern is already changing in Virginia with the proliferation of HMO prepaid support programs and may change dramatically in the next decade. At the Medical College of Virginia, many of the "service patients" who do not have their own private physicians are treated on a rotational basis. From one month to the next, there is a new physician or physician team responsible. In Sweden today, depending upon the day of the week, you are assigned, in a socialized system, a totally new physician. The continuity of care or the contractual interest of the physician is not something that a patient can take for granted.

I point this out to indicate to you that the assumption that humanistic or legalistic interactions will take place is totally false unless you indicate in your bill the need for a formalized structure that makes dialogue between those responsible for life withdrawal possible. We have no such structure here at M.C.V., despite my efforts!

I feel that the following mechanisms should be established:

1. All intensive care units (ICU's) or ICU equivalent, must have a designated informational committee, "Life Support Committee" consisting of a hospital administrator, the primary care physician of the patient, the ICU physician, an ICU nurse and a lay representative, i.e., chaplain, trustee, etc. The goal of this committee is informed consent for life withdrawal.

2. The creation of such committees should be ordained by the State Board of Health who will ensure their existence and monitor compliance.

3. If a patient, in an intensive care unit, or on life support systems is considered to be terminally ill by the attending and/or intensive care unit physician, that a document to that effect be presented to the family.

If the family or guardian so desires, a formal committee hearing regarding the situation can be asked for prior to the removal of life support systems or the removal of the patient from the intensive care unit to a less adequate support environment.

4. The family, or the guardian of the patient, can, at weekly intervals, request a meeting with a representative of the ICU "Life Support" committee. This committee will fully inform the patient's family or representative of the opinion of the physicians and the staff that the patient is in a terminal phase and that further maintenance of extraordinary measures are inappropriate or appropriate for a definite or indefinite time.

5. When a patient is removed from the ICU, the family or guardian is told in writing, as to the reason for transfer.

The above is a mechanism to assure informed consent.

Following the above exchange, the procedure for withdrawal of life support can be conducted.

Outside of ICU's, your bill is adequate because heroic measures to keep people alive do not stand a sustained chance without the intensive nursing support that is the family or guardian's responsibility.

6. In regard to physician liability: I feel there should always be the safeguard of the courts that if, for any reason, a patient's family or guardian feels that life withdrawal was improperly achieved.

I fear the absolute removal of physician liability as indicated in this bill is going to change the mindset of the community which could make withdrawal of life support so much easier. I feel that the protection of physicians from liability should be implied, but not absolute!

Please circulate this to other members of the committee. It is my feeling that the life termination responsibility for ICU's should be a State Board of Health charge akin to certification.

I commend you for your efforts and would hope to discuss my thoughts about this at the legislative hearings and/or individually with you and your committee members.

My best regards,

Sincerely yours,

William Regelson, M.D.
Professor of Medicine

WR/e

CC: Bishop Sullivan

APPENDIX B5

INSTITUTE OF
LAW, PSYCHIATRY AND PUBLIC POLICY
UNIVERSITY OF VIRGINIA

SCHOOL OF LAW
Charlottesville, Virginia 22901
804-924-7895

Please reply to:
SCHOOL OF MEDICINE
Box 100, Blue Ridge Hospital
Charlottesville, Virginia 22901
804-924-5435

December 28, 1982

Mary P. Devine
Division of Legislative Services
General Assembly Building
910 Capitol Street
P.O. Box 3-AG
Richmond, Virginia 23208

Re: Draft Natural Death Act

Dear Ms. Devine:

Thank you for sending me a copy of your Committee's draft of the Natural Death Act.

Having lectured to physicians, nurses, and law students occasionally on this subject, I am aware of the enormously complex moral and legal issues with which your Committee has grappled. While I commend you for taking on a problem of such scope and I am sure that your efforts will result in much-needed legislation, I do think the present draft is less than ideal. While I would be happy to elaborate on my criticisms if you are interested, it seemed important that your Committee consider (if they have not already) a few issues. It also might be worth distributing to the members of the Committee the recently released report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment (Partial Revised Draft November 1982).

Most importantly, you have almost wholly ignored the problems relating to competency. I say almost because you do seem to call for the witnesses to the written (but not the oral) declaration to attest to the patient's "sound mind." You also seem to require the patient to be an adult. You do arrange for the appointment of surrogate decisionmakers where the patient is "physically or mentally incapable of communication." Because of these and other minor features of the draft, I gather you have considered to some extent this issue of competency. More consideration, however, is needed to the following kinds of questions.

Can an adult capable of communicating, but with no developed preferences or values, or incapable of assessing his present condition and the treatment options, or incapable of understanding how those options advance such values as he has, make a valid declaration?

Or, is such a person "mentally incapable of communicating," thus authorizing a surrogate to make a decision for him?

As drafted, it is likely under the Act that persons whose decisionmaking (as distinct from their ability to communicate) is impaired, will make declarations binding (to some extent, anyway, under Section -----:8) on his physician.

It also is likely that such a person who does not make a declaration, would not have a surrogate act for them. Section ---:3, among its other defects, permits the use of a surrogate only where ability to "communicate" is totally impaired. It also does not authorize anything; it only (and rather unnecessarily) purports to not prohibit certain procedures. This language along with that in Section ---:12 leaves everything exactly as it now stands under the common law and existing guardianship statutes. And I really doubt that under existing law any of the surrogates you list have the authority to terminate life-sustaining treatment. Even if the guardian had otherwise plenary authority over medical care of the ward (and many have their authority restricted to the ward's estate or to particular medical issues), cases like Saikewicz suggest that the guardian nonetheless would need specific court approval of such a decision, unless the statute specifically authorized such a decision.

The competency to make a revocation is also ignored. While some states specifically authorize an incompetent revocation as a safeguard of the patient's right to continued treatment, it should be recognized that this impairs the patient's right to self-determination, i.e., his right to provide in a declaration that his subsequent "incompetent" statements should be ignored.

Similarly, the written declarations executed before the onset of the illness should only be relied on if the patient is incompetent, or, if competent, he confirms orally his intent to be allowed to die. The form of the declaration in Section ---:6 obscures this kind of protection. On the one hand the second paragraph of the model written declaration "directs" the physician to withhold or withdraw services upon the physician's rendering a certain diagnosis. On the other, the next paragraph suggests that the declaration only be honored "[i]n the absence of my ability to give directions." In light of the bill's requirement that declarations, but not revocations "promptly" be made part of the patient chart, it is possible that a competent patient who wishes to prolong his life will be allowed to die because a recent re-assessment of his preferences and competency was not conducted.

In practice I really doubt that there is much of a risk that will happen, just as I doubt that this draft would assist in cases where it is needed, because of the narrow definition of "life prolonging procedures" and the overriding ambiguities of the common law.

As I will describe in a greater detail later, the Act seems to control only "life prolonging procedures" where death is imminent even with the procedure. In those instances the potential loss of dignity, waste of resources, etc., are minimal. Legislation should address the use of life-prolonging procedures where with the use of the procedure death from the illness is inevitable, but not imminent. So while the harm that might be caused by the Act as it now is worded is negligible, it is also of little usefulness unless the kind of medical care and patients subject to it are changed. Other language in Section ---:3 and Section ---:12 also contributes to rendering this Act worthless.

A few less important points also should be considered:

1) Surrogate decisionmakers should be given a standard of decisionmaking, e.g., an elaboration of the "best interests" or "substituted judgment" standards. The usual formulation of the latter favors both more than those of the former.

2) Multi-disciplinary review panels ought to be used to advise or decide in cases where competency is doubtful or diagnosis uncertain. Specific legal effect should be assigned to their decisions or those of surrogates who receive their approval.

3) Section ---:11 should discuss withdrawal of services.

4) Consistent terminology should be employed throughout definitions of "qualified patient", "terminal illness", and "life-prolonging procedure," and the model declaration. In particular, the definition for life prolonging procedure (LPP) is so qualified as to render the Act of little usefulness. The Act only permits withholding or withdrawal of a LPP. A LLP is paradoxically defined as a procedure for prolonging life ("the dying process") where death is "imminent whether or not such procedure. . .is utilized." Given the restrictiveness of this definition, most of the definition of "terminal illness" goes without saying. The important conditions of being a "qualified patient", e.g., competence, having reached the age of 18, etc., are omitted. Only the exclusion of pregnant women is really significant.

5) Section ---:9's consideration of insurance should address accidental death coverage and incentives in health insurance that might promote the use of declarations. For example, an insurance company might offer coverage at a lower

premium to "qualified patients." the premium for non-declaring patients would rise correspondingly. I would prohibit such incentives for a variety of reasons, despite the fact that to do so may force the insured declarant to pay for the treatment he will never want and may have strong moral objections to.

6) What effect does the somewhat unusual hortatory language in Section ---:1 have? How does "the General Assembly hereby declares that the laws. . .shall. . ." fit with Section ---:12's ". . .shall not impair any existing rights or responsibilities." Particularly with regard to patients incapable of giving near-contemporaneous informed consent to "the provision or the withholding or withdrawal of life-prolonging medical procedures," I am, as I have said earlier, concerned that you have left matters worse than they now stand, controlled by common law and judicial interpretation of the guardianship statutes but with many health care providers believing that your act immunizes them from liability.

There are, I think, solutions to these problems. For example, Section 11-9.1 could be amended to clearly allow durable powers of attorney which cover health care decision-making, and which can be triggered by a disability, terminal illness, etc.

Section 37.1-134.2 might be amended to include judicial authorization of DNR, "no code" "slow code" or other orders to which the patient is unable to consent, at least where a terminal diagnosis is present.

In any event, I hope you find my comments helpful. Please let me know if I can assist you in any way.

Sincerely yours,

Willis J. Spaulding,
Director, Mental Health Law
Training and Research Center

WJS/ls

APPENDIX B6

VSHL

December 29, 1982

Mary P. Devein, Esquire
Division of Legislative Services
Post Office Box 3-AG
Richmond, Virginia 23208

Dear Ms. Devine:

Enclosed you will find a letter to the members of the Study Committee on the Rights of the Terminally Ill. I would appreciate your sending a copy to the committee members.

Thank you for your cooperation.

Sincerely,

Margaret H. Disney
Office Secretary
Virginia Society for Human Life

mhd
Enclosure

cc: Mrs. Lena R. Harknett

— AFFILIATED CHAPTERS —
☐ BLACKSBURG - 260 Country Drive, #10, Christiansburg 24073 ☐ FRANKLIN COUNTY - P.O. Box 53, Ferrum 24088 ☐ FREDERICKSBURG - P.O. Box 1323, Fredericksburg 22401 ☐ LYNCHBURG - P.O. Box 3292, Lynchburg 24503 ☐ NORTHERN VIRGINIA - P.O. Box 511, Annandale 22003 ☐ PENINSULA - P.O. Box 1333, Hampton 23661 ☐ PRINCE WILLIAM AREA CITIZENS FOR LIFE - P.O. Box 1145, Manassas 22110 ☐ RICHMOND - 1 N. Fifth Street, Richmond 23219 ☐ ROANOKE - P.O. Box 4821, Roanoke 24015 ☐ TIDEWATER - P.O. Box 8213, Norfolk 23503

APPENDIX B6

VIRGINIA SOCIETY FOR HUMAN LIFE
VSHL
1 North Fifth St. • Richmond, Virginia 23219
Telephone 804/782-9774

December 29, 1982

TO: Members of the Study Committee on the Rights of the Terminally Ill

SUBJECT: Comments on the proposed bill "Natural Death Act of Virginia"

Dear Committee Member:

It has long been the policy of the Virginia Society for Human Life to oppose the establishment of a legal document that would mandate a death policy. The Board of Directors of VSHL will study the proposed "Natural Death Act" in depth at its meeting in early January.

In the meantime, we have reviewed the latest draft under discussion and have some very serious reservations regarding

1. Revocation. Medical history is full of instances where a person is ill, unable to communicate and yet aware. That person would be in no position to revoke his declaration if he so desired.

2. Immediacy of death. Medical history is also replete with cases where death was considered imminent by a doctor or doctors. Yet the patient improved and was able to return to a relatively normal existance.

3. Consultation. There is no requirement for second medical opinions in all cases.

4. Terminal illness. The definition of terminal illness is vague and open to many interpretations. All of us could be considered to be terminal in our race through the stages of life. It can even be said with accuracy that when we begin to exist, we begin to die. Many of us have illnesses which are incurable but controllable with proper artificial means -- diseases such as diabetes, lupus, multiple sclerosis, and pernicious anemia, to name just a few. There is no provision in the act for the continuation of treatment for the existing "terminal illness" when a person is hospitalized for a separate and distinct medical problem.

VIRGINIA SOCIETY FOR HUMAN LIFE
VSHL
1 North Fifth St. • Richmond, Virginia 23219
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5. Vulnerability of a physician who provides heroic measures. Nothing in the draft protects a physician who by his own medical determination coupled with a respect for human life - orders what might be considered extraordinary measures for a patient.

6. Vulnerability of a patient who has not made a declaration. If the Natural Death Act becomes a law of the Commonwealth, then physicians of patients who have not signed a declaration may become overcautious about discontinuing treatment at the appropriate time, thereby causing excessive hardship and expense for patient and family.

7. Pressure on the patient. There is throughout the proposed act, including the policy statement 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 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. Thus, the act could serve as a cover-up or hindrance to the proper care of the elderly, the seriously ill, and especially the dying.

8. Alteration of physician responsibility. Doctors should be using their medical expertise to examine each patient on a case-by-case basis. Under the act, however, physicians may feel constrained by the legal limitations of the declarations and the law surrounding them and discontinue treatment too soon. Inevitably, some patients will die who might have recovered.

9. Descriptive terms of treatment. The terms natural and artificial when applied to treatment seem to us to be open to many interpretations. In actual fact, it could be said that almost all hospital treatment could be described as artificial regardless of its simplicity. It would seem to us that there is a great difference between ordinary artificial means and extraordinary artificial means.

VIRGINIA SOCIETY FOR HUMAN LIFE

VSHL

1 North Fifth St. • Richmond, Virginia 23219
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10. Lack of informed consent. The "extraordinariness" of extraordinary means is determined by actual, factual circumstances. What the "declaration" does is convert a choice in the future to a choice in the present, long before one has met the real circumstances, much less thoughtfully considered them. Signing such a document is not unlike signing a blank check.

11. Food and sustenance. The addition to the draft of the clause providing for the withdrawal of food or sustenance causes us great concern. The refusal of man's basic nutritional need is viewed by us as a form of suicide.

12. No demonstrated need. Legally, patients already have the common law right to refuse extraordinary care, which is at issue in this type of legislation. There has been demonstrated no compelling need for a statutory declaration. We are aware of the physician fear which has been engendered by the wide publicity given to the "hard" cases make bad law. Also, given the complexity of the wording of the proposed act, there could well be a proliferation of court cases, serving only to increase, not diminish, physician fear.

13. Final result. And finally, despite the disclaimer, the proposed bill is a foot in the door toward euthanasia. The idea of this legislation was originated by the Right to Die Society, well known to be the right arm of the Euthanasia Educational Society. The eventual aim of these groups is to legalize all kinds of euthanasia with the handicapped, the unwanted and the burdensome as special targets. They have stated on innumerable occasions that they can't push for active euthanasia at this point because of the objections on the part of the medical profession, legislators and the public. They hope by seemingly innocuous efforts such as living will legislation gradually to erode such opposition and pave the way for their final aim.

We realize that the intent of this committee is not that of the pro-euthanasia people. The results, however, might well be in keeping with their goals.

In summary, it appears to us that the enactment of this type legislation may result in more problems than it will solve. It is virtually impossible to write a bill comprehensive enough to cover the special circumstances of each patient's medical condition, which would be essential for the practice of good medicine and good law.

Lena R. Harknett

Lena R. Harknett
Co-Chairman Legislative Committee
Virginia Society for Human Life

LRH/mhd

Lena R. Harknett
9517 Cragmont Drive
Richmond, Virginia 23229
Tel: 804/740-1084

APPENDIX B7

Diocese of Arlington
Chancery Office
SUITE 704
200 NORTH GLEBE ROAD
ARLINGTON, VIRGINIA 22203
(703) 841-2500

December 30, 1982

While believing that withdrawal of life-saving equipment is permissible when it is extraordinary and would only uselessly prolong the dying state without hope of recovery or any benefit, and that the individual may so choose this, and granting that the state has a necessary concern in such matters, we still oppose the proposed Natural Death Act. We oppose it basically because we can see no need for it and are concerned that an unnecessary law regulating a complicated situation can make the situation far worse. What does the proposed legislation permit that is not already allowed? Under common law there is a right to refuse treatment (Satz vs. Perlmatter; Eichner vs. Dillon 1980; Karen Quinlan Case, New Jersey Supreme Court 1976) and physicians can effectively withdraw emergency medical treatment by the order "Do not resuscitate" (DNR) (Massachusetts Appellate Court, 1978, 1982).

The proposed bill does not use the traditional terms "extra-ordinary" and "ordinary" leaving room for vagueness in what treatment can be stopped. The bill does not define "artificial" which could cover everything from eye-glasses to hemodialysis. The fact that a life procedure would only serve to postpone the moment of death does not help unless it applies to a person in the dying state. Otherwise a person on dialysis could qualify since he would die if he did not get the treatment, also a person who is a diabetic would qualify since he would die without his insulin.

Another problem we have with the Act is the written declaration of the patient which is a living will even though the words are not used. The great majority of patients are unlikely to ever execute such a declaration and physicians may be reluctant to withdraw or withhold life-sustaining equipment without an official directive. Presently such matters are dealt with by the attending physician and the pateint and if he is comatose, then by his nearest kin. We cannot see how this proposed declaration would help. On the contrary it may well be a hindrance.

Finally, we oppose any legislation dealing with the withholding of life-sustaining equipment which does not guarantee that required medical and surgical procedures be given to infants born with severe handicaps so that what happened in Bloomington Hospital in Indiana with Infant Doe will never happen in the Commonwealth of Virginia.

Thomas J. Welsh

Most Reverend Thomas J. Welsh
Bishop of Arlington

Westminster
Canterbury

1600 Westbrook Avenue • Richmond, Virginia 23227
Telephone (804) 264-6000

January 3, 1983

We the undersigned residents and/or friends of Westminster-Canterbury House, Richmond, Virginia do hereby affirm our support of the Natural Death Act of Virginia designed to enable persons of sound mind to instruct medical authorities to withhold heroic life support measures thereby ensuring a peaceful death with dignity. Furthermore, we encourage others, particularly the elected members of the Virginia General Assembly to promote and enact this measure with all possible haste.

Carter Brooke Osserman Muller

Roswell Negus

Marguerite T. Kinzer

Virginia W. Smith

Virginia Smethers

Corinne E. Allegree

Sarah G. Riddick

Blanche Lanier

Elizabeth Wright Brown

Frances C. Branch

Mary S. Richardson

Elizabeth Richardt

Sarah K. Robertson

Agnes Heald

Cliffie Wilson

Pauline Wert

Rose Donelan Dugard

Lillian H. Crumpler

Elizabeth M. Airey

Kay Francis

Mrs. A. O. Kratzer

Frances C. Gresham

J. O. Pollard

Westminster Canterbury

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Evelyn L. Holmes
Mary Allan McClure
Ada Nash Carlton
William W. Michaux
Eleanor H. Smith
Janie E. Wood
Martha H. Chappell
Ida B. Currie
Helen J. Hanmer
Emily B. Grainger
Berta N. Hogg
Berta M Pierce
Mary S. King
Margaret F. Compton

Thomas G. Bass Sr.
Aubrey Y. Kiser
Rebekah S. Lee
Elizabeth B. Arrasmith
Lee B. Guerrant
Jno. G. Guerrant
Mary D. Lynn
Irene T. Ommundsen
Mr & Mrs A. Robert Tower
Dr. & Mrs Herbert D Wolff
Antoinette C Button
Henry Miller
Ulricka Miller
Annie Tignor
Mrs Wm C. Davis

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Ruth E. Gran
Emma Lee Patterson
Lucy C. [illegible]
[illegible] Gray
Wm. G. Talley
Margaret Constable
Isabel B. Snoddy
Isabella K. Light
Ellen V. Gilchrist
Dorothy W. Kunkle
John H. Foster
George H. Brumble
Emelie J. Haverton
Virginia [illegible] Coghill
Helen Van O. Winter

Alice Hall
Kathleen Greene
Elisabeth S. Woolard
Agnes Moyler Jones
J. Howard M[illegible]
[illegible] Lewis
Matilda Wood West
Elizabeth G. Freeland
[illegible] Stuart
Dorothy D. Wingfield
Margaret McNeal Burton
Pat [illegible]
Linda B. Williams
Elizabeth T. C[illegible]
Henry Brimm
Jo Brimm

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Elizabeth T. Little
Betty W. Roberts
Nancy Barker
J. F. Johnson
Viola Borkey
Elizabeth M. Junken
[illegible]
E. W. Patterson
Gilbert I. Dawe
Blanche W. Mason
Mary Burke Elder
C. L. Watkins
Helen H. Loving
William D. Gammie
Margaret C. Gammie
Helen Honey

Elizabeth Gilman
Virginia T. Hyde
Laura A. Carroll
Dorothy S. Regien
Martha C. Michaux
Virginia D. Ryland
Miriam Best Blake
Beatrice S. Baldwin
Mary D. Cappelmann
Elizabeth O. Morison
Ruth V. Thornton
Grace Drumwright
Ralph H. Fowler
Dorothy O. Johnson
Alberta W. Bowles
E. Jeffries Heinrich
Elsie B. Feick

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Nellie George Peebles
Catherine T. Barrett
Ella T. Floyd
Allen C. Floyd
Elizabeth G. Woodson
Anne P. Brydon
Eleanor G. Link
Mary R. Butterworth
Rose Lee Norman
Katherine Aulick
Mr. & Mrs. James T. Ebelinger
Lilla W. Hancock
Katherine G. Hancock
Margaret Pritchard
Elizabeth B. Macdonald
Hans G. von Schweinitz
Fred W Faber
Alfred Wi
Lucy W. Christian
Mrs L. R. Jackson
Mrs. Fielding Jeter
Wm. D. Duncan
Rose C. Macon
Anne N. Ruffin
Virginia B. Wilson

Westminster Canterbury

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January 3, 1983

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Patricia R Kawara
Marilyn D. Maloney
Jessie Waring
Flora Parrish
Harriett C. Percivall
Ola M. Stagg
Liz-Nett W. Richeson
Callie Faber
Fred Faber
Mabel Dunn
Margaret S. Stokes
Florence Bailey
Mabel E Montgomery
Elinor W. Curry
Harriet B. Schoolf

Frances J. Bolea
Carrie [illegible]
Emily Mustain
Nancy Amohundro
Frederick W Herrmann

APPENDIX C

Circuit Court of Alexandria
Virginia

Courthouse
520 King Street
Alexandria, Virginia 22314
(703) 838-4123

January 11, 1982

C. Torrence Armstrong, Esquire
Boothe, Prichard & Dudley
Post Office Box 1101
Alexandria, Virginia 22313

Thomas W. Barham, Esquire
Barham, Radigan, Suiters & Brown
Post Office Box 966
Arlington, Virginia 22216

Re: Alexandria Hospital v. McLellan
Chancery No. 13009

Gentlemen:

This petition is filed pursuant to the provisions of § 37.1-134.2 of the Code of Virginia. The petitioner prays that the Court authorize such medical treatment as may be necessary to sustain the life of Andrew McLellan. The petition alleges that Andrew McLellan and his wife wish to withdraw him from further life sustaining treatment, which will result in his death and that neither he nor Mrs. McLellan are capable of giving informed consent to the withdrawal of said treatment.

It is clear from the evidence presented at the hearing of this cause on January 7, 1982, that Mr. McLellan is gravely ill and that the prognosis for his recovery is poor. He is presently receiving respiratory therapy and kidney dialysis, without both of which he cannot survive. He has expressed his wish to discontinue all life sustaining efforts and to die. The issue before the Court for decision is whether he is capable of making this determination.

Under the provisions of § 37.1-134.2 the court may authorize treatment only "upon finding on the basis of clear and convincing evidence that the person is incompetent or incapable as so alleged and that the proposed treatment is medically necessary."

It is without question that the present treatment is medically necessary for the preservation of Mr. McLellan's life. On the issue of his competence, it is the opinion of the Court that the evidence falls far short of the required burden of proof. The petitioner has failed to prove Mr. McLellan's incompetence by clear and convincing evidence. The evidence, taken as a whole, demonstrates that Mr. McLellan is in command of his mental faculties and is legally competent. It shows further that he has made an informed judgment, and is fully cognizant of the consequences of his proposed actions. Having reached this conclusion, the Court must decline to grant the relief sought by the petitioner and will dismiss the petition.

Although the dismissal of the petition effectively terminates this matter, it seems appropriate to comment on an issue that was raised at the hearing dealing with Mr. McLellan's right to discontinue further medical efforts to prolong his life. It is obvious that termination of the life sustaining efforts of the medical care providers will result in his death. Having found him legally competent and sufficiently informed to make an informed judgment, does he have the right to discontinue further medical treatment, when to do so will surely result in his death?

There are no Virginia appellate decisions which provide direction on this question. Nor has the Legislature enacted legislation on the subject. Accordingly, the Court must look for guidance to other jurisdictions which have considered this question. The compelling need for prompt decision in this case prohibits the Court from writing an exhaustive opinion analyzing the complex social, ethical and legal issues involved. The Court has, however, read all of the legal authorities cited by counsel, as well as others disclosed by its own research.

The Court is most impressed with the rationale of the decisions in Superintendent of Belchertown v. Saikewicz, Mass., 370 N.E.2d 417 (1977) and Satz v. Perlmutter, Fla., 362 So.2d 160 (1978). It is the opinion of the Court that Mr. McLellan has the legal and moral right to make this decision. He has the unfettered right to control his own destiny. A competent, adult patient has the right to refuse treatment for himself, and if he has this right, he has a concomitant right to discontinue such treatment, in the absence of a compelling state interest to the contrary. In this case, the Court is of the opinion that the state's interest in preserving life, protecting innocent third parties, preventing suicide and maintaining the ethical integrity of the medical practice is overborne by Mr. McLellan's constitutional right of privacy and his right to individual free choice and self determination.

Mr. Barham is requested to prepare an order dismissing the petition for the reasons stated herein, have it duly endorsed by Mr. Armstrong and present same to the Court for entry.

Very truly yours,

Albert H. Grenadier

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A BILL to amend the Code of Virginia by adding in Chapter 12 of Title 54 an article numbered 7.1, consisting of sections numbered 54-325.8:1 through 54-325.8:13, establishing the Natural Death Act of Virginia; penalties.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 12 of Title 54 an article numbered 7.1, consisting of sections numbered 54-325.8:1 through 54-325.8:13, as follows:

Article 7.1.

Natural Death Act.

§ 54-325.8:1. Policy statement; short title.--The General Assembly finds that all competent adults have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, withheld or withdrawn.

The General Assembly further finds that the artificial prolongation of life for persons with a terminal condition may cause loss of individual dignity and secure only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the patient.

In order that the dignity, privacy and sanctity of persons with such conditions may be respected even after

they are no longer able to participate actively in decisions concerning themselves, the General Assembly hereby declares that the laws of the Commonwealth of Virginia shall recognize the right of a competent adult to make an oral or written declaration instructing his physician to withhold or withdraw life-prolonging procedures or to designate another to make the treatment decision for him, in the event such person is diagnosed as suffering from a terminal condition.

The provisions of this article shall be known and may be cited as the "Natural Death Act of Virginia."

§ 54-325.8:2. Definitions.--As used in this Act:

"Attending physician" means the primary physician who has responsibility for the treatment and care of the patient.

"Declaration " means (i) a witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of § 54-325.8:3 or (ii) a witnessed oral statement, made by the declarant subsequent to the time he is diagnosed as suffering from a terminal condition and in accordance with the provisions of § 54-325.8:3.

"Life-prolonging procedure" means any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging

procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

"Physician" means a person licensed to practice medicine in the Commonwealth of Virginia.

"Qualified patient" means a patient who has (i) made a declaration in accordance with this Act and (ii) been diagnosed and certified in writing by the attending physician, (and, in any case where the patient is comatose, incompetent or otherwise physically or mentally incapable of communication, by one other physician who has examined the patient) to be afflicted with a terminal condition. A patient who is known by the attending physician to be pregnant shall not be deemed a qualified patient during the term of the pregnancy.

"Terminal condition" means a condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty, (i) there can be no recovery and (ii) death is imminent.

"Witness" means a person who is not a spouse or blood relative of the patient.

§ 54-325.8:3. Procedure for making a declaration; notice to physician.--Any competent adult may, at any time, make a written declaration directing the withholding or withdrawal of life-prolonging procedures in the event such person should have a terminal condition. A written declaration shall be signed by the declarant in the presence

of two subscribing witnesses. An oral declaration may be made by an adult in the presence of a physician and two witnesses by any nonwritten means of communication at any time subsequent to the diagnosis of a terminal condition.

It shall be the responsibility of the declarant to provide for notification to his attending physician that a 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 a declaration. An attending physician who is so notified shall promptly make the declaration or a copy of the declaration, if 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.

§ 54-325.8:4. Suggested form of written declaration.--A declaration executed pursuant to this Act may, but need not, be in the following form, and 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 (i) diagnosed as suffering from a terminal condition and (ii) comatose, incompetent or otherwise mentally or physically incapable of communication. Should any other specific directions be held to be invalid, such invalidity shall not affect the declaration.

Declaration made this _____ day of _____ (month, year). I, _____, willfully and voluntarily make known my desire that my dying shall not be

artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, 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 shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

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

§ 54-325.8:5. Revocation of declaration.--A declaration may be revoked at any time by the declarant (i) by a signed, dated writing; or (ii) by physical cancellation or destruction of the declaration by the declarant or another in his presence and at his direction; or (iii) by an oral expression of intent to revoke. Any such revocation shall be effective when 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.

§ 54-325.8:6. Procedure in absence of declaration; no presumption.--Nothing in this Act shall be construed in any manner to prevent the withholding or the withdrawal of life-prolonging procedures from an adult patient with a terminal condition who (i) is comatose, incompetent or otherwise physically or mentally incapable of communication and (ii) has not made a declaration in accordance with this Act, provided there is consultation and agreement for the withholding or the withdrawal of life-prolonging procedures between the attending physician and any of the following individuals, in the following order of priority if no

individual in a prior class is reasonably available, willing and competent to act:

1. The judicially appointed guardian or committee of the person of the patient if one has been appointed. This paragraph shall not be construed to require such appointment in order that a treatment decision can be made under this section;

2. 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 illness; or

3. The patient's spouse; or

4. An adult child of the patient or, if the patient has more than one adult child, by a majority of the children who are reasonably available for consultation; or

5. The parents of the patient; or

6. The nearest living relative of the patient.

In any case where the treatment decision is made by a person specified in paragraph 3, 4, 5, or 6, there shall be at least two witnesses present at the time of the consultation when the treatment decision is made.

The absence of a declaration by an adult patient shall not give rise to any presumption as to his intent to consent to or refuse life-prolonging procedures.

§ 54-325.8:7. Transfer of 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 (i) by the declarant in his declaration or (ii) pursuant to § 58-325.8:6 shall make a

reasonable effort to transfer the patient to another physician.

§ 54-325.8:8. Immunity from liability; burden of proof; presumption.-- A health care facility, physician or other person acting under the direction of a physician shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of the withholding or the withdrawal of life-prolonging procedures from a patient with a terminal condition in accordance with this Act. 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 § 54-325.8:6 shall not be subject to criminal prosecution or civil liability for such action.

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 this Act. A declaration made in accordance with this Act shall be presumed to have been made voluntarily.

§ 54-325.8:9. Willful destruction, concealment, etc. of declaration or revocation; penalties.--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, thereby causing life-prolonging

procedures to be utilized in contravention of the previously expressed intent of the patient shall be guilty of a Class 6 felony.

Any person who falsifies or forges the declaration of another, or 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 thereby, because of such act, directly causes life-prolonging procedures to be withheld or withdrawn and death to be hastened, shall be guilty of a Class 2 felony.

§ 54-325.8:10. Mercy killing or euthanasia prohibited.--Nothing in this Act 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.

§ 54-325.8:11. Effect of declaration; suicide; insurance; declarations executed prior to effective date.--The withholding or withdrawal of life-prolonging procedures from a qualified patient in accordance with the provisions of this Act shall not, for any purpose, constitute a suicide. Nor shall the making of a declaration pursuant to this Act affect the sale, procurement or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated by the withholding or withdrawal of

life-prolonging procedures from an insured qualified patient, 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.

The declaration of any qualified patient made prior to the effective date of this Act shall be given effect as provided in this Act.

§ 54-325.8:12. Preservation of existing rights.--The provisions of this Act are cumulative with existing law regarding an individual's right to consent or refuse to consent to medical treatment and shall 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 Commonwealth.

§ 54-325.8:13. Severability.--If any provision of this Act is held invalid, such invalidity shall not affect other provisions of the Act which can be given effect without the invalid provision. To this end, the provisions of this Act are severable.

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