VIRGINIA'S NATURAL DEATH ACT: IS IT USEFUL TO INDIVIDUALS IN A PERSISTENT VEGETATIVE STATE?

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> As scientific advances make it possible
> for us to live longer than ever before,
> even when most of our physical and mental
> capacities have been irrevocably lost,
> patients and their families are increasingly
> asserting a right to die a natural death
> without undue dependence on medical technology
> or unnecessarily protracted agony - in short,
> a right to die with dignity.[1]

INTRODUCTION

One of the most controversial medical, moral and legal issues of our time is whether patients in a persistent vegetative state (PVS) have a legal right to die. "The most commonly cited estimate of the number of PVS patients in the United States is 5,000 to 10,000, and this number can be anticipated to significantly increase in the future, especially when coupled with their increased longevity."[2] This article will discuss this issue in four sections. The first section will define what it means to be in a PVS in an attempt to reconcile some of the common misconceptions associated with this condition. The second section will discuss the rights of such patients to discontinue treatment as well as the rights of a surrogate to act on their behalf. The third section will explore Virginia's Natural Death Act[3] to see if it effectively deals with PVS patients. Finally, this article will suggest possible solutions to this ongoing controversy.

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[1] *In re* Conroy, 98 N.J. 321, ___, 486 A.2d 1209, 1220 (1985).

[2] Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CENTER REP. 27, 31 (Feb.-Mar. 1988).

[3] VA. CODE ANN. §§ 54.1-2981 to -2992 (1988 & Supp. 1989).

PVS patients are said to be in a state of "permanent unconsciousness".[4] They have lost all cognitive functions, they do not experience anything.[5] These individuals are not simply demented, they are amented.[6] They are not merely retarded, they have lost all mental capacities. However, these patients are not terminally ill[7] in the traditional sense. PVS individuals commonly live five, ten, twenty years or more if care is maintained,[8] although they are not able to enjoy many of the pleasures normally associated with living. "There is virtually no chance that such a [PVS] patient will ever recover consciousness."[9]

Given these circumstances one might wonder whether PVS patients should be considered alive at all. They are not totally brain dead. Their brain stem, which controls such functions as breathing and reflexes, is still intact. Yet they have lost the very capacities that make us human and separate us from other animals. Many commentators argue that because of this loss of "personhood," PVS patients should be considered brain dead.[10] As it stands now, the Uniform Determination of Death Act

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[4] Cranford, *The Persistent Vegetative State: The Medical Reality (Getting The Facts Straight)*, 18 HASTINGS CENTER REP. 27, 28 (Feb.-Mar. 1988) (citing to PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 171-92 (March 1983)).

[5] *Id.* at 31.

[6] *Id.* at 28. Amented is defined as having no mind and demented is defined as deprived of reason. STEDMAN'S MEDICAL DICTIONARY 50, 373 (5th ed. 1982).

[7] Terminal illness is defined as an illness which occurs at or contributes to the end of life. STEDMAN'S MEDICAL DICTIONARY 1418 (5th ed. 1982).

[8] Cranford, *supra* note 4, at 31.

[9] Annas, *Do Feeding Tubes Have More Rights Than Patients?*, 15 HASTINGS CENTER REP. 26 (Feb. 1986).

[10] Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850, 858 n. 39 (1986).

does not include PVS patients in its definition of death.[11] Thus, PVS patients are not legally dead,[12] but they experience none of the joys of being alive. The question that logically follows then is, should such individuals be given the "right to die"?

SHOULD PVS PATIENTS HAVE THE RIGHT TO DIE?

The best known "right to die" case is that of Karen Ann Quinlan.[13] Karen was a twenty-two year old woman in a PVS. The doctors believed that she would die very soon if taken off her respirator.[14] The court held that her physicians could pull the plug on her respirator at the request of her parents.[15] However, when her father was asked if he wanted her nasogastric feeding tube removed, he replied, "Oh no, that is her nourishment."[16] As a result, Karen lived for nine years in a PVS.

The single most troubling issue in determining if PVS patients have the "right to die" is that in many cases they will only die if their artificial hydration and nutrition

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[11] The Uniform Determination of Death Act § 1, 12 U.L.A. 271 (Supp. 1985), provides: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."

[12] The Virginia Code, § 54.1-2972, defines legal death to be either (1) irreversible cessation of spontaneous respiratory and spontaneous cardiac functions, or (2) irreversible cessation of spontaneous brain functions and spontaneous respiratory functions. VA. CODE ANN. § 54.1-2972 (1988).

[13] *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

[14] *Id.* at ___, 355 A.2d at 655.

[15] *Id.* at ___, 355 A.2d at 671-72.

[16] Ramsey, *Prolonged Dying: Not Medically Indicated*, 6 HASTINGS CENTER REP. 14, 16 (Feb. 1976).

(AN&H) system is withdrawn.[17] Inherently, there seems to be something morally and ethically wrong with denying any patient food and water. It is somehow different from withholding other medical treatment.[18] When a respirator or similar life support system is disconnected, a patient is simply allowed to die naturally, and the underlying disease is the cause of death. However, when AN&H is withdrawn, the patient is being starved to death, and an active and unnatural killing is taking place.[19] Thus, the fear is that society will embark down a slippery slope toward the endorsement of euthanasia or suicide as the solution rather than simply allowing a person to die a natural death.[20]

Although the inherent morality of this theory may be very appealing, the harsh reality of carrying it through has led many courts to decide in favor of withholding or withdrawing AN&H.[21] Unfortunately, the courts seem to reach this result because of their desire to do the right thing and fail to apply any clear and consistent legal principles to guide us. The determination that allowing PVS patients to forego AN&H is the right thing seems to be based on two basic premises.

First, it has long been recognized that patients who are competent to determine the course of their therapy may refuse any and all interventions proposed by others, as

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[17] Artificial nutrition and hydration (AN&H) is the provision of food and water through medical intervention. There are two basic procedures which provide the required nutrients. The first is a nasogastric tube which is inserted through the nose into the stomach. The second is a gastrostomy tube (G-tube) which is surgically inserted directly into the stomach. *See generally*, Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP. 17 (Oct. 1983).

[18] *See generally*, Derr, *Why Foods and Fluids Can Never Be Denied*, 16 HASTINGS CENTER REP. 28 (Feb. 1986).

[19] *Id.* at 28.

[20] *See generally*, Wikler, *Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State*, 18 HASTINGS CENTER REP. 41 (Feb.-Mar. 1988).

[21] *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); McConnell v. Beverly Enterprises, 209 Conn. 692, 553 A.2d 596 (Conn. 1989); Delio v. Westchester County Med. Center, 516 N.Y.S.2d 677 (N.Y. App. Div. 1987); *In re* Gardner, 534 A.2d 947 (Me. 1987); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

long as their refusals do not seriously harm or impose unfair burdens upon others.[22] Second, it is assumed that few people would opt to continue such an existence if given the choice, because their lives would not be worth living.[23] However, these premises provide little assistance in the absence of a pre-written document, such as a living will,[24] because PVS patients are incompetent by definition. This leaves courts in the unenviable position of having to balance the underlying assumption that many of these patients would choose to forego AN&H if they were competent against the state's interest in the sanctity of life.[25]

Perhaps some of the biggest strides in dealing with this issue were made by the New Jersey Supreme Court in deciding *In re Conroy*.[26] Claire Conroy was a single, eighty-four year old woman with serious and irreversible physical and mental impairments. She was legally incompetent and had only minimal cognitive capacities. Her only living relative, a nephew, was appointed her legal guardian. Her nephew filed suit to have her AN&H, which was provided through a nasogastric tube, withdrawn. The court declared termination of any medical treatment, including AN&H, for incompetents lawful so long as certain procedures are followed.[27] In reaching this

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[22] *See* Lynn & Childress, *supra* note 17, at 18.

[23] Wikler, *supra* note 20, at 41.

[24] Living will is a common term used to refer to a patient's prior written instruction that a physician withhold life-sustaining procedures in certain circumstances. For a detailed discussion of living wills, *see* Dufraine, *Living Wills - A Need for Statewide Legislation or a Federally Recognized Right?*, 3 DET. C. L. REV. 781 (1983).

[25] Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741, 370 N.E.2d. 417, 425 (1977). The court asserts four countervailing state interests; 1) preservation of life; 2) protection of third parties; 3) prevention of suicide; and 4) maintenance of the ethical integrity of the medical profession. *Id.* at 741, 370 N.E.2d at 425.

[26] *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

[27] Annas, *When Procedures Limit Rights: From Quinlan to Conroy*, 15 HASTINGS CENTER REP. 24, 25 (Apr. 1985).

decision, the court specifically rejected some of the most common arguments set forth by the proponents of mandatory AN&H. The court found no difference between allowing a person to die and the hastening of the death process by terminating treatment;[28] between withholding and withdrawing treatment;[29] between extraordinary and ordinary care;[30] and between AN&H and other life sustaining procedures.[31] Based on the foregoing analysis, the court set out a three part test to apply when the patient is incompetent and unable to express his/her own desires. First, if the individual's wishes can be determined, no further inquiry is required.[32] The patient's wishes must be granted based on his/her common law right to refuse any medical treatment.[33] Alternatively, when the patient's wishes are not discernible, the court set forth two "best interests" tests. The "limited objective test" allows life sustaining treatment to be withdrawn if there is some evidence the patient would refuse treatment and the burdens imposed by the treatment outweigh the benefits the patient receives.[34] The "pure objective test" is to be applied when there is absolutely no evidence about what the patient would want. This test requires that the burden imposed clearly outweigh the benefits to the patient and the unavoidable and severe pain of the patient's life must be such that the effect of administering treatment would be inhumane.[35] The severity of

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[28] Conroy, 98 N.J. 321, ___, 486 A.2d 1209, 1233-34 (1985).

[29] *Id.* at ___, 486 A.2d at 1234.

[30] *Id.* at ___, 486 A.2d at 1234-35.

[31] *Id.* at ___, 486 A.2d at 1235-36.

[32] *Id.* at ___, 486 A.2d at 1229-30. The court notes that the patient's wishes could be embodied in a "living will," deduced from prior oral statements, deduced from religious beliefs, a consistent pattern of conduct, or a durable power of attorney. *Id.*

[33] *Id.* at ___, 486 A.2d at 1226.

[34] *Id.* at ___, 486 A.2d at 1232.

[35] *Id.*

the third test is based on the court's belief that "[w]hen evidence of a person's wishes or physical or mental condition is equivocal, it is best to err, if at all, in favor of preserving life."[36]

While the court has certainly made progress in setting forth clear legal standards, there are still problems with its approach. First, the procedural requirements are narrowly tailored for nursing home patients.[37] Thus, the legal standards are far too rigorous to be applied generally. More importantly, the tests themselves are severely flawed. The self-determination test is both legally and morally sound, but there will rarely be enough evidence to apply it. While logically sound, the "best-interests" tests are inapplicable to PVS patients because these patients can't experience anything. Therefore, it is impossible to discern how any medical intervention could benefit or harm them.[38] In these instances, the only justifiable reason to sustain their life is "for their loved ones and the community at large."[39] Presently, it is generally accepted that if the parents feel strongly that no AN&H should be provided, and the caregivers are willing to comply, the law should not stand in the way.[40] However, this principle offers no assistance when family members and caregivers disagree. Some courts have dealt with this by allowing the patient to be moved to a hospital that would honor the family's wishes.[41] This "compromise" puts an extra strain and certainly an added financial imposition on a family that has already endured a great deal. Perhaps a better

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[36] *Id.* at ___, 486 A.2d at 1233.

[37] *Id.* at ___, 486 A.2d at 1240-43.

[38] Lynn & Childress, *supra* note 17, at 18.

[39] *Id.*

[40] *Id.* (citing to PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 171-196 (March 1983)).

[41] Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E. 2d 626 (1986).

solution would be to apply the benefits versus burdens analysis to the family. In a very real sense, the family members are the ones suffering. It is they who are incurring the severe financial burden,[42] and the emotional strain. It therefore seems more logical that this analysis, if at all, be applied to the family members, who are indeed burdened, rather than the PVS patient who can experience nothing.

Another commonly asserted argument against withholding AN&H is that it leads to a horrible and gruesome death and not the dignified experience we associate with "natural death."[43] The symptoms associated with this dying process are a dried mouth, lips parched and cracked, tongue swollen and cracked, eyes sunk back into their orbits, cheeks hollow, nose bleeding and stomach dried out causing dry heaves and vomiting.[44] While seemingly justifiable, these concerns are wholly unwarranted. With adequate nursing care and good oral hygiene, PVS patients will not incur these horrible effects.[45] Further, only family members, who might witness the manifestation of these symptoms, would need protection because PVS patients cannot experience pain and suffering.[46]

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[42] Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CENTER REP. 27, 31 (Feb.-Mar. 1988). "The cost of maintaining [PVS] patients varies substantially by state, type of institution and support systems. *Id.* In general, the costs range from $2,000 to over $10,000 a month. *Id.*

[43] *See generally*, Battin, *The Least Worst Death*, 13 HASTINGS CENTER REP. 13 (Apr. 1983).

[44] Brophy, 398 Mass. at 444 n.2, 497 N.E.2d at 641 n.2 (Lynch, J., dissenting).

[45] Cranford, *supra* note 42, at 31.

[46] Cranford, *supra* note 42. "No conscious experience of pain and suffering is possible without the integrated functioning of the brain stem and cerebral cortex. Pain and suffering are attributes of consciousness, and PVS patients like Brophy do not experience them. Noxious stimuli may activate peripherally located nerves, but only a brain with the capacity for consciousness can translate that neural activity into an experience. That part of Brophy's brain is forever lost." *Id.* (citing to Brophy v. New England Sinai Hospital, Inc., Amicus Curiae Brief, American Academy of Neurology, Minneapolis, MN (1986)).

Finally, the withdrawal of AN&H will result in death in one to thirty days, making it a fairly quick process.[47]

IS THE VIRGINIA CODE EFFECTIVE IN DEALING WITH PVS PATIENTS?

The Virginia Natural Death Act[48] allows a competent adult to make a written declaration[49] directing the withholding or withdrawal of life-prolonging procedures in the event such person should have a terminal condition.[50] In the absence of a written declaration directing withdrawal, life-prolonging procedures may be withdrawn from a comatose or incompetent patient, with a terminal condition, provided there is agreement between the attending physician and the court-appointed guardian or certain other individuals.[51] A terminal condition is defined by the Act to mean "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."[52] This seemingly restrictive and vague definition would provide little assistance to a PVS patient.

The first judicial interpretation of the Act construed the terminal condition provision narrowly. The case, decided in 1986, was *Hazelton v. Powhatan Nursing Home*.[53] Mrs. Hazelton had a malignant brain tumor which caused her to slip into an irreversible coma. The attending physician, her husband and two adult children all agreed that her AN&H, supplied through a nasogastric tube, should be withdrawn. However, the Powhatan Nursing Home, where Mrs. Hazelton was staying, refused to

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[47] *Id.*

[48] VA. CODE ANN. §§ 54.1-2981 to -2992 (1988 & Supp. 1989).

[49] VA. CODE ANN. § 54.1-2983.

[50] *See* VA. CODE ANN. § 54.1-2982.

[51] VA. CODE ANN. § 54.1-2986.

[52] VA. CODE ANN. § 54.1-2983.

[53] Chancery No. 98287 (Cir. Ct. of Fairfax County, Va., Aug. 29, 1986).

honor the attending physician's request. The Circuit Court of Fairfax County held that Mrs. Hazelton's illness satisfied the terminal condition provision and ordered withdrawal of the nasogastric tube.[54] The court relied on the testimony of four medical experts in determining if the Act's two-part test defining a terminal condition was met.[55] While all four experts agreed that "there could be no recovery," there was dissension as to whether the "death must be imminent requirement" had been satisfied.[56] The court determined that Mrs. Hazelton met the "death must be imminent" requirement because her illness would lead to death within a few months regardless of treatment. This narrow reading of the provision does not help PVS patients who could live for several years.[57] In fact, the court specifically stated that the statute does not apply to "those who are in a coma but are not afflicted with a disease or other treatment that will specifically lead to their death."[58] The Act further prohibits "any affirmative or deliberate act or omission to end life other than to permit the natural process of dying."[59] This terminology certainly opens the door for an abundance of litigation as to whether the withdrawing or withholding of AN&H ends life in a way other than the natural process of dying.[60] The Act, as it now reads, helps a very small group of people and fails to aid those with the greatest need. Arguably, PVS patients who are

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[54] Hazleton, slip op. at 1-2.

[55] *Id.* at 11-12.

[56] *Id.* at 5.

[57] Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CENTER REP. 27, 31 (Feb.-Mar. 1988) (citing to Cranford, *Termination of Treatment in the Persistent Vegetative State*, Seminars in Neurology 4(1): 36-44 (Mar. 1984)). "The longest reported, well documented, survival (without recovery) was thirty-seven years, 111 days." *Id.*

[58] Hazleton, slip. op. at 6.

[59] VA. CODE ANN. § 54.1-2990.

[60] *See generally*, Derr, *Why Foods and Fluids Can Never be Denied?*, 16 HASTINGS CENTER REP. 28 (Feb. 1986).

forced to live a life devoid of human experiences,[61] for several years,[62] placing tremendous financial[63] and emotional stress on their families have a greater need for the "right to die" than someone who will die shortly regardless of the court's decision.

The Act is also of little utility in that it requires the attending physician and the family or guardian to agree.[64] It has already been recognized that under such circumstances of agreement, the law should not stand in the way.[65] Instead, the law needs to provide guidance when these parties are in dispute. The Act is clearly ineffective in achieving this goal.

Further, the written declaration sections[66] is virtually devoid of value. Based on the doctrine of informed consent, individuals have a basic common law right to refuse any medical treatment, so long as it does not place undue burdens on others.[67] The written declaration provision only allows competent individuals to refuse life-prolonging medical procedures if they fall within the Act's narrow definition of terminal condition. The Act specifically purports not to impair existing common law rights[68] and therefore there is no practical reason to draft a provision that falls far short of those rights.

The Virginia courts have had little opportunity to apply the Act to date. Unfortunately, the restrictiveness of the Act coupled with the vagueness of the "terminal

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[61] Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CENTER REP. 27, 28 (Feb.-Mar. 1988).

[62] *Id.* at 31.

[63] *Id.* at 31-32.

[64] VA. CODE ANN. § 54.1-2986.

[65] Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP. 17, 18 (Oct. 1983) (citing to PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 171-96 (March 1983)).

[66] VA. CODE ANN. § 54.1-2983.

[67] *See generally*, Lynn & Childress, *supra* note 65.

[68] VA. CODE ANN. § 54.1-2992.

condition" provision will leave them with little guidance when the need arises. This situation could result in a contradictory body of case law and necessitates the broadening of the Act to provide a uniform approach to "right to die" decisionmaking within the state.[69] Similar problems have arisen in other states with restrictive natural death acts.[70] This is largely because courts are ruling, with increasing frequency, that common-law and constitutional rights to refuse treatment supersede restrictive legislative directives.[71] The courts recognize that the patient's rights are not unconditional[72] and must be balanced against the State's interest in life. However, most court's have found it "difficult to conceive of a case in which the State could have an interest strong enough to subordinate a patient's right to choose not to be sustained in a persistent vegetative state."[73] Therefore, in order to be of any use to the courts and citizens of Virginia, the Act should be redrafted to be both more comprehensive and more conclusive. Specifically, a redrafted statute needs to include PVS patients, a group the current statute virtually overlooks.

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[69] Note, *The "Terminal Condition" Condition in Virginia's Natural Death Act*, 73 VA. L. REV. 749, 766 (1987).

[70] The restrictive natural death acts in California and Washington caused the courts in those states to create their own ad hoc solutions to the complex non-treatment cases before them. *Id.* at 763-66.

[71] Note, *A Necessary Compromise: The Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-Sustaining Procedures Act*, 47 MD. L. REV. 1188, 1205 (1988).

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> The privacy right involved, therefore, cannot be said to be absolute. In fact, it is not clear to us that the claim asserted by some amici that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions.

Roe v. Wade, 410 U.S. 113, 154 (1973).

[73] *In re* Peter, 180 N.J. 365, ___, 529 A.2d 419, 427 (1987).

PROPOSALS FOR REFORM

There are two possible resolutions to the current ineffectiveness and inconsistencies in the law with respect to the rights of PVS patients. The first involves redefining the legal definition of death to include those who are in a state of permanent unconsciousness. The permanent unconsciousness of an individual is sometimes referred to as neocortical death.[74] A redrafting of the statute would allow the withholding or withdrawal of all life-support systems, including AN&H, from PVS patients without

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[74] Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850, 875 (1986). Smith proposes a model statute which reads as follows:

Neocortical Death

Sec. 1. For the purpose of this statute, "neocortical death" means the irreversible loss of consciousness and cognitive functions. An individual who has sustained neocortical death is legally dead. A determination of neocortical death under this section must be made in accordance with reasonable medical standards and procedures.

Sec. 2. After a medical determination of neocortical death, the individual may be biologically maintained if the individual has executed a written instrument [in accordance with the jurisdiction's living will statutes or procedures] expressing the desire to be maintained on artificial life-support systems in the event of neocortical death. If the individual has made no such prior written declaration, the family, next of kin, or guardian may provide for biological maintenance.

Sec. 3. If neither the individual (by a prior written directive) nor the family, next of kin, or guardian elects to provide for biological maintenance, all artificial life-support systems may be withheld and terminated, and the provision of nourishment and fluids may be withheld or ceased. As an alternative to the withholding or cessation of nourishment and fluids as a means of terminating biological existence, the family, next of kin, or guardian may request injection of a chemical in a quantity sufficient to cause biological death. The chemical must be administered in accordance with reasonable medical procedures.

Sec. 4. No person, firm, or organization shall be subject to criminal responsibility or civil liability for terminating the biological existence of a neocortically dead individual by any of the methods or procedures authorized in Section 3 (withholding or terminating artificial life-support systems, cessation of nourishment and hydration, or lethal chemical injection).

Id. at 875-76.

controversy. In fact, if the revised statute followed the existing death statutes, the patient's wishes for termination of treatment would not have to be ascertained.[75]

There are several reasons why including neocortical death in the definition of legal death makes sense. First, as stated earlier, many courts are already finding a way to allow the withdrawal of AN&H from PVS patients, due to the severity of their affliction.[76] The revised statute would simply provide clear and consistent reasoning for the decisions that many state courts have already been reaching. Thus, unnecessary litigation could be avoided. Also, the traditional benefits versus burdens analysis used in "right to die" cases breaks down when applied to PVS patients.[77] The late Senator Jacob Javits stated, while himself suffering from a terminal illness, that "[b]ecause medical technology can now sustain life even when the ability to think is gone, society must change its laws."[78] Finally, it is virtually impossible to know with any certainty, in the absence of a prior written directive, what the wishes of a person devoid of mental capacities would be. Classifying these patients as legally dead would relieve the courts from their duty to do the impossible and protect individuals from the emotional and financial stress generally incurred in litigating the issue.

The revised statute would also rebut some of the most common arguments asserted by proponents of mandatory AN&H. For example, one argument is that withdrawing AN&H is actively killing the PVS patient as opposed to allowing him to die a natural death.[79] The conflict of whether it was the underlying disease or starvation

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[75] *Id.* at 860 n. 44.

[76] *See* cases cited *supra* note 21.

[77] Lynn & Childress, *Must Patients Always Be Given Food and Water*, 13 HASTINGS CENTER REP. 17, 18-19 (Oct. 1983).

[78] Smith, *supra* note 74, at 860 n.44 (citing to *Former Senator Pleads for Dignified Death*, Am. Med. News, Oct. 25, 1985, at 13, col. 2).

[79] *See generally*, Derr, *Why Foods and Fluids Can Never be Denied*, 16 HASTINGS CENTER REP. 28 (Feb. 1986).

that caused the patient's death[80] would be resolved because the patient would be declared legally dead before the AN&H was withdrawn. Moreover, many commentators argue that the withdrawing of AN&H from PVS patients, will allow society to embark down a "slippery slope"[81] which will eventually lead to active euthanasia of physically and mentally handicapped individuals. This fear could be eliminated by the proposed redefinition of legal death.[82] Under the new statute, only individuals who were in a state of permanent unconsciousness, who had lost all cognitive functions, and who could experience nothing would be classified as legally dead. The courts should still apply the benefits versus burdens analysis to anyone who was severely handicapped but could, to some extent, experience joy and pain.

One of the purposes of law is to provide clear and consistent guidelines for members of society to abide by. The current ad hoc decisionmaking by courts,[83] with regard to the rights of PVS patients and their families, is of little use in this regard. The result is costly and time consuming litigation for families that have already endured a great deal of heartache and expense. Further, the current definition of death has other negative implications. As the law reads now, death benefits cannot be received by PVS patients or their families, vital organs cannot be donated to save someone who might be able to lead a full life[84] and murderers can go unpunished for years, until a PVS

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[80] Steinbock, *The Removal of Mr. Herbert's Feeding Tube*, 13 HASTINGS CENTER REP. 13, 14-16 (Oct. 1983).

[81] *See generally*, Wikler, *Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State*, 18 HASTINGS CENTER REP. 41 (Feb.-Mar. 1988).

[82] Smith, *supra* note 74, at 861 n.51.

[83] Note, *The "Terminal Condition" Condition in Virginia's Natural Death Act*, 73 VA. L. REV. 749, 766 (1987).

[84] Superintendent of Belchertown State School v Saikewicz, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977). The state's interest in sanctity of life would certainly be promoted by allowing vital organs to be donated to individuals who might otherwise die. *Id.*

victim is pronounced dead.[85] These grave effects could all be avoided by adopting a revised statute which defines legal death to include neocortical death.

The first proposal assumes that no one would want to remain in a state of permanent unconsciousness. This assumption, while clearly supported by some,[86] may not be unanimously backed. Smith[87] proposes that we allow some PVS patients to be biologically maintained. This exception, although compassionately designed, will make the inclusion of PVS patients among the legally dead look like "definitional gerrymandering."[88] The expansion of legal death must not simply be a means to a desired end, it must be based on independent medical grounds. Therefore, if PVS patients are to be considered legally dead, it is imperative that they are treated as such in every respect. However, if the redefinition of death seems unconscionable to many, there is an alternative solution. The "living will"[89] doctrine could be expanded both in its content and its availability. The Virginia Natural Death Act[90] only allows a living will to mandate the withholding or withdrawal of life-prolonging procedures in the case of a terminal condition. Thus, the written directive section[91] must be expanded to allow individuals to carry out their constitutional and common law right[92] to refuse any medical treatment. The legislature could achieve this by revising the Act to allow a living will to include the denial of life-prolonging measures for the patient who loses

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[85] Smith, *supra* note 74, at 872 n.128.

[86] *Id.* at 858 n.39.

[87] *Id.* at 856-77.

[88] Wikler, *supra* note 81, at 44.

[89] *See generally*, Dufraine, *Living Wills - A Need for Statewide Legislation or A Federally Recognized Right?*, 3 DET. C.L. REV. 781 (1983).

[90] VA. CODE ANN. §§ 54.1-2981 to -2992 (1988 & Supp. 1989).

[91] VA. CODE ANN. § 54.1-2983.

[92] Lynn & Childress, *supra* note 77, at 18.

all cognitive abilities and enters a state of permanent unconsciousness. Further, in order to be truly effective, the availability of living wills must be brought to the public's attention. Members of society should be encouraged to draft a living will just as they are encouraged to vote or encouraged to become organ donors. Unfortunately, expanding the use of living wills would not achieve the level of consistency that redefining death provides. However, it is certainly a positive step in protecting the rights of PVS patients and a viable solution for those who are not ready to include such individuals among the legally dead.

CONCLUSION[93]

PVS patients do not enjoy any of the experiences that make us human. Yet as long as they are biologically maintained, their families are prevented from getting on

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[93] In 1988, the Supreme Court of Missouri overruled a trial judge's decision to allow the withdrawal of AN&H from Nancy Cruzan at the request of her parents. Cruzan v. Harmon, 760 S.W.2d 408 (Mo. banc 1988), *cert. granted*, 109 S. Ct. 3240 (1989). Nancy Cruzan was a twenty-five year old woman in 1983 when she was involved in a one car accident which caused her to stop breathing for approximately 12 to 14 minutes. *Id.* at 411. The deprivation of oxygen caused severe brain damage. Nancy Cruzan lies in a persistent vegetative state today.

Approximately one month after the accident, on February 7, 1983, a gastrostomy feeding tube was implanted. *Id.* At that time there was still hope for recovery. Today, that hope is gone. "The evidence is clear and convincing that Nancy will never interact meaningfully with her environment again." *Id.* at 422. Yet, it is predicted that Nancy "will live a life of relatively normal duration if allowed basic sustenance." *Id.* at 419.

The Missouri Supreme Court held that Missouri's strong interest in life outweighs any right that Nancy's guardians have to refuse medical treatment on her behalf. *Id.* at 426. The court reached this decision despite the fact that when other courts have considered the issue, "nearly unanimously, those courts have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought." *Id.* at 413.

The Cruzans appealed to the United States Supreme Court and the case was argued on December 6, 1989. However, a decision has not yet been handed down. This is the first "right to die" case to reach the Supreme Court and the decision should help to define the rights held by PVS patients and their families. Although, as with the regulation of the right to have an abortion performed, great discretion may be given to the individual states in this area.

At this point, the effect of the Supreme Court's decision on Virginia's Natural Death Act is unknown and any speculation on the issue is beyond the scope of this article. The purpose of this article is merely to point out that the Act is currently of little value to many PVS patients and their families.

with their lives and incur thousands of dollars in medical bills every month. Most people would not opt to remain in such a condition, yet the law is presently unclear as to how they can avoid it. The Natural Death Act of Virginia is both too restrictive and too vague to aid PVS patients. The statute should be revised in one of two ways. It should either include PVS patients among the legally dead or guarantee them their rights through expansion of the living will doctrine. Due to the length and severity of their condition, PVS patients, possibly more than any other group, need and deserve the "right to die" with dignity.