

**STANDARDS OF SUBSTITUTE JUDGMENT
FOR APPLYING SURROGATE TREATMENT DECISIONMAKING
FOR INCOMPETENT ADULTS IN VIRGINIA**

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INTRODUCTION

In the Spring, 1990, issue of the *Colonial Lawyer*,¹ Deborah A. Ryan criticized the Virginia Natural Death Act and its narrow definition of persistent vegetative state.² This article will discuss Section 37.1-134.4 of the Virginia Code that authorizes, among other things, an appointed surrogate to provide, withhold, and withdraw life-sustaining medical treatment for certain incompetent persons.³ This statute is one of the most progressive in the country, as evidenced by the number of cases from other jurisdictions that underscore their state legislature's lack of action in this area.⁴

Because Section 37.1-134.4 is a relatively new statute, Virginia courts have little statutory interpretation. As a result, Virginia must look to decisions in other state courts in order to give guidance to those making health care decisions for an incompetent adult. This article will first discuss the requirements of the statute itself and then address the medical evidence necessary to support the different standards of substitute judgment decisionmaking. Next, the article will discuss the three different standards of substitute judgment available to a decisionmaker when fulfilling the statute's requirements: (1) the substitute-intent standard, (2) the limited-objective standard, and (3) the pure-objective standard. These standards will then be balanced

¹ Ryan, *Virginia's Natural Death Act: Is It Useful to Individuals in a Persistent Vegetative State?*, 19 COL. LAW. 34 (1990).

² See VA. CODE ANN. §§ 54.1-2981 to -2992 (1988 & Supp. 1990).

³ VA. CODE ANN. § 37.1-134.4 (Supp. 1990). See Appendix A.

⁴ See cases discussed *infra*.

against five state interests: (1) preserving life, (2) protecting innocent third parties, (3) preventing suicide, (4) maintaining the medical profession's ethical integrity, and (5) the cost of medical care. Finally, the article will conclude that Virginia has provided a workable solution for surrogates making medical decisions for incompetent adults.

THE VIRGINIA SURROGATE DECISIONMAKING STATUTE

In Section 37.1-134.4 of the Virginia Code, the Virginia General Assembly has provided for substituted consent to medical treatment in the case of an incompetent and terminally ill adult patient.⁵ Since the General Assembly has already weighed the

⁵ VA. CODE ANN. § 37.1-134.4 (Supp. 1990). *See also* VA. CODE ANN. § 54.1-2986 (1988). This statute, the Natural Death Act, limits substituted consent decisionmaking by providing that:

Life-prolonging procedures may be withheld or withdrawn 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 article, provided there is consultation and agreement for the withholding or the withdrawal of life-prolonging procedures between the attending physician and [certain individuals to refuse treatment on behalf of the patient].

See also, Note, *The 'Terminal Condition' Condition in Virginia's Natural Death Act*, 73 VA. L. REV. 749, 750 (1987). Under the Natural Death Act, a patient has a "terminal condition" if "there is 'a reasonable degree of medical certainty [that] (i) there can be no recovery and (ii) [the patient's] death is imminent.'" *Id.* (quoting VA. CODE ANN. § 54.1-2982 (1988)). Under the statute, life-prolonging procedures may be withdrawn from only a "qualified patient." *Id.* at n.8. A "qualified patient" is defined as one who has a "terminal condition." *Id.* "Terminal," however, does not clearly define a medical condition. *Id.* Colloquially, "terminal" is equated with incurability. *Id.* In medicine, however, many chronic diseases, such as chronic congestive heart failure, are rarely terminal. *Id.* For medical purposes, the word "imminent" is rarely defined. *Id.* at 150 n.11.

See also, Note, *The Virginia Natural Death Act - A Critical Analysis* 17 U. RICH. L. R. 863, 871-72 (1983) [hereinafter *Critical Analysis*]. *But see* Letter From Attorney General Gerald L. Baliles to The Honorable G. Steven Agee, Member, House of Delegates (August 2, 1983), regarding the issue of whether one may, pursuant to the Virginia Natural Death Act, have the use of kidney dialysis, intravenous feeding, and oxygen withdrawn or terminated as life-prolonging procedures under the provisions of VA. CODE ANN. § 54.1-2982 (1988):

A different result would undoubtedly follow if oxygen were administered by

benefits and burdens of substituted consent,⁶ this article will focus on the standards that are available to the decisionmaker making a substituted judgment for an incompetent adult. By restricting this article to the case of an adult who was formerly competent, this article avoids the slippery slope argument, predicting that the use of substituted judgment will result in the forced termination of care for society's "undesirables," that is more readily available when the adult always lacked competency.⁷ The case of an adult who could never have been found competent is similar to the more difficult cases of infants, children, and other so-called "incompetents," such as the mentally retarded, where federal statutes may be implicated.⁸ For this reason, these cases are beyond the scope of this article.

In examining the standards the decisionmaker may utilize, this article assumes that the identity of the decisionmaker is not relevant to the choice of the standard used. The Virginia Statute lists the order of priority of those who may authorize the withholding or withdrawal of treatment: (1) anyone given such authority in a writing pursuant to Virginia Code Section 54.1-2984; (2) an authorized guardian; (3) anyone appointed under a durable power of attorney that grants such authority to decide,

different means for the purpose of supplanting the spontaneous function of breathing; similarly, a different result would undoubtedly follow if intravenous feeding was not for the purpose of providing comfort against dehydration but was mainly for the purpose of supplanting the spontaneous functions of receiving necessary nourishment into the body in amounts adequate to maintain life. In both situations, of course, before terminating the procedure, it would be necessary for the physician first to find that the patient was in a terminal condition and that the process served only to prolong the dying process.

⁶ See *Critical Analysis*, *supra* note 5, at 870-71.

⁷ See *Matter of Storar and Eichner*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

⁸ See 42 U.S.C. §§ 5106a-5106h (1988) (The Child Abuse Prevention and Treatment Act requires that states, in order to receive certain federal funds, meet certain legal and administrative standards ensuring that the state's protective services respond to "medical neglect" cases).

provided that they are not employed by the doctor or anyone employing the doctor; (4) a husband or wife; (5) an adult child; (6) parent(s); (7) an adult sibling; or (8) any other relative, to be decided in descending order of blood relationship.⁹ Any of these individuals should come to the same conclusions when applying the standards set forth in this article.

Section 37.1-134.4 of the Virginia Code¹⁰ specifies procedures available for surrogate treatment decisionmaking.¹¹ While the statute mandates that the surrogate base his decision on the "best interests" of the person, the statute contains language that requires the surrogate to consider factors that are clearly part of the "substituted intent" standard. The statute provides, for example, that it does "not authorize providing, continuing to provide, withholding or withdrawing treatment if the [person providing] the treatment knows or upon reasonable inquiry ought to know that such an action is protested by the person."¹² Also, no person can authorize treatment that he knows, or ought to know, "is contrary to the religious beliefs or basic values of the person unable

⁹ VA. CODE ANN. § 37.1-134.4(B) (Supp. 1990); *See* VA. CODE ANN. §§ 11-9.1 to - 11-9.2 (1989) (concerning durable power of attorney); *see* Appendix B. *But see* VA. CODE ANN. § 54.1-2986 (1988). The order of priority of the decision makers in Section 54.1-2986 of the Natural Death Act is as follows:

1. The judicially appointed guardian or committee of the patient if one has been appointed . . . ; or
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 condition; 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.

¹⁰ VA. CODE ANN. § 37.1-134.4 (Supp. 1990).

¹¹ *Id.* at § 37.1-134.4(H).

¹² *Id.* at § 37.1-134.4(D) (Supp. 1990).

to make a decision, whether [the beliefs or values are] expressed orally or in writing."¹³ These factors require the decisionmaker to try to determine what the individual would have wanted, and not what the decisionmaker, in the first instance, believes to be in the "best interests" of the incompetent individual. Therefore, in interpreting this statute, the courts should view the statute as creating a hybrid "substitute intent" -- "best interest" standard.

THE DOCTRINE OF SUBSTITUTE JUDGMENT

To examine the standards of the doctrine of substitute judgment, the doctrine itself must be clearly defined. The law supports the idea that incompetence does not deprive an individual of the right to decide treatment questions.¹⁴ This right remains as if the patient were still competent.¹⁵ Someone else, however, must exercise this right for the incompetent individual.¹⁶ The decision is a substitute for the patient's own, and is therefore called "substitute judgment."¹⁷ The law recognizes a constitutional right to "bodily privacy, found in the penumbras of various fundamental rights"¹⁸ Along with the tort principles that prohibit nonconsensual touching,¹⁹ that right to bodily

¹³ *Id.*

¹⁴ D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING § 15:2, at 470 (1981).

¹⁵ *Id.* at 471 (citing Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977)); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied* 429 U.S. 922 (1976)).

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ Brant, *The Right To Die in Peace: Substituted Consent And The Mentally Incompetent*, 11 SUFFOLK U.L. REV. 959, 960 (1977).

¹⁹ *Id.* at 961 (citing *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (competent adults may determine when they will consent to treatment); *Schloendorff v. Soc. of N.Y. Hosp.*, 211 N.Y. 125, 126, 105 N.E. 92, 93 (1914) (surgeon performing operation without adult patient's consent

privacy can be extended to disallow medical care without the patient's informed consent.²⁰ The doctrine of substitute judgment extends this right to the incompetent individual who is not able to grant his/her consent by allowing another to act for the incompetent in a manner consistent with the incompetent's wishes had he/she remained competent.²¹

The number of cases discussing this doctrine has increased due to the advances in medical technology that have allowed a person with "minimal brain functioning" to be sustained without being deemed brain dead.²² Courts, however, have been grappling with the issues of whether, when and by whom medical treatment may be withdrawn from an incompetent person since Karen Quinlan lapsed into a coma on April 15, 1975.²³ The courts are still looking for answers. Most recently, with the case of Nancy

commits assault).

²⁰ *Id.* (citing *In re Quinlan*, 70 N.J. 35, ___, 355 A.2d 647, 662 (1976) (court allowed patient in vegetative state to be withdrawn from respirator)).

²¹ Weber, *Substitute Judgment Doctrine: A Critical Analysis*, 1 ISSUES IN L. & MED. 131, 135 (1985).

²² *John F. Kennedy Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984). As the court in *Bludworth* stated:

It is now possible to hold such persons on the threshold of death for an indeterminate period of time by utilizing extraordinary mechanical or other artificial means to sustain their vital bodily functions. The procedures used can be accurately described as a means of prolonging the dying process rather than a means of continuing life.

Id.

The Florida Supreme Court held that in the case of a terminally ill and comatose patient who had executed a "living" will, "it is not necessary that a court-appointed guardian of his person obtain approval of [the] court . . . before terminating extraordinary life support systems in order for consenting family members, attending physicians, and hospital and its administrators to be relieved of civil and criminal liability" *Id.* at 926. Merely good faith is necessary. *Id.*

²³ *In re Quinlan*, 70 N.J. 10, ___, 355 A.2d 647, 653-54 (1976). On April 15, 1975, Karen Quinlan stopped breathing at least twice, for fifteen-minute periods at a time. *Id.* at ___, 355 A.2d at 653-54. She was left in a persistent vegetative state. *Id.* at ___, 355 A.2d at 654. The New Jersey Supreme Court held that the right to terminate her life by removing her life-support was incident to her right of privacy which could be asserted on her behalf by her guardian. *Id.* at ___, 355 A.2d at 664.

Cruzan, the Supreme Court essentially left the states free to determine the standards they will require before allowing the withdrawal of medical care, including food and water, from an incompetent individual.²⁴ As Harvard Law School Professor Laurence Tribe notes, however, the *Cruzan* case reveals the unprecedented recognition by eight Supreme Court justices of some degree of constitutional protection for the "right to die."²⁵ These cases continue to arise because the courts have failed to spell out standards for the substitute decisionmaker to apply in determining what the incompetent patient would decide if still competent.

MEDICAL EVIDENCE

When making a health-care decision for an incompetent, the decisionmaker must decide and carry out, to the degree possible, the care the individual, if competent, would have chosen.²⁶ The court in *In re Peter*, however, noted that before making any health-care decisions, the decisionmaker must understand the patient's medical condition and likelihood of recovery.²⁷ Therefore, "[t]he focal point of such decisions should be

²⁴ See *Cruzan ex rel. Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc). Nancy Cruzan was left in a persistent vegetative state after an auto accident deprived her brain of oxygen for an estimated twelve to fourteen minutes (the trial judge found that deprivation of six minutes results in permanent brain damage). *Id.* at 410-11. When efforts to rehabilitate Nancy over a substantial period of time failed, her parents (acting as her guardians) sought a judicial order sanctioning their belief that Nancy would want her artificial nutrition and hydration terminated. *Id.* The Circuit Court ordered that the request be carried out, *id.* at 411, but the Missouri Supreme Court reversed this decision, noting the state policy of preserving life and finding no "legal basis which permits the coguardians in this case to choose the death of the ward." The United States Supreme Court affirmed the Missouri Supreme Court decision in *Cruzan ex rel. Cruzan v. Director, Missouri Dept. of Health*, ___ U.S. ___, 110 S. Ct. 2841 (1990).

²⁵ The Washington Post, July 2, 1990, at A5, col. 1.

²⁶ N. CANTOR, *LEGAL FRONTIERS OF DEATH AND DYING* 63 (1987) [hereinafter CANTOR] (citing *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1229 (1985)).

²⁷ *In re Peter*, 108 N.J. 365, ___, 529 A.2d 419, 428 (1987). In 1984 Hilda Peter lapsed into a persistent vegetative state. *Id.* at ___, 529 A.2d at 428. Ms. Peter had effected a power of attorney, which authorized her friend, Eberhard

whether there is a reasonable medical expectation of the patient's return to a cognitive life as distinguished from the forced continuance of a vegetative existence."²⁸ This inquiry can be made by looking for two factors set out by the court in *Foody v. Manchester Memorial Hospital*: (1) "the incapable patient's condition . . . is permanent and irreversible and there is no reasonable medical probability that the patient ever will return to a cognitive state, [and] (2) the patient's attending physician together with at least two other consulting physicians unanimously concur as to the patient's condition"²⁹ These factors insure that the patient truly requires a substitute decisionmaker to carry out his wishes regarding increased or continued medical care.

Once the decisionmaker determines that the patient has no reasonable possibility of regaining his or her cognitive abilities, the decisionmaker should begin to weigh the other medical factors. The court in the *Peter* case followed *Quinlan* concluding "that

Johanning, to make her health-care decisions. *Id.* at ___, 529 A.2d at 422. As her guardian, Johanning requested that Peter's nasogastric tube be withdrawn. *Id.* at ___, 529 A.2d at 422. The New Jersey Supreme Court set the standard of proof necessary to avoid judicial review in a substituted judgment case as clear and convincing. *Id.* at ___, 529 A.2d at 427. *See also* VA. CODE ANN. § 37.1-134.4(E) (Supp. 1990). This section provides that:

Prior to the initiation or cessation of treatment for which authorization has been obtained or will be sought pursuant to this section, and no less frequently than every 180 days while the treatment continues, the physician shall obtain a written certification that the person is incapable of making an informed decision regarding the treatment. This certification shall be made by a licensed physician or licensed clinical psychologist who is not otherwise currently involved in the treatment of the person assessed and shall be based on a personal examination of the person. The cost of the assessment shall be considered for all purposes a cost of the treatment provided.

²⁸ John F. Kennedy Hosp., Inc. v. Blutworth, 452 So. 2d 921, 926 (Fla. 1984).

²⁹ *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, ___, 482 A.2d 713, 721 (1984). Sandra Foody had suffered from severe multiple sclerosis for 24 years, when, at age 42, she "suffered a respiratory arrest" leaving her unable to breathe without a respirator and in a semicomatose state. *Id.* at ___, 482 A.2d at 715-16. Her family brought an action to restrain the hospital staff and doctors from using artificial means to continue Sandra's breathing and heart rate. *Id.* at ___, 482 A.2d at 713. The court ruled in favor of allowing a substitute decision to be made for Sandra because there was no state interest sufficient to override her rights. *Id.* at ___, 482 A.2d at 720.

the life-expectancy of the patient . . . is not an important criterion," especially when the patient is in a persistent vegetative state.³⁰ Nancy Cruzan, for example, could live in such a state for thirty more years.³¹

The court in *Barber v. Superior Court* stated that a determination should be made as to whether the proposed treatment will benefit or burden the patient.³² The court then explained that "the determination as to whether the burdens of treatment are worth enduring for any individual patient depends on facts unique to each case, namely, how long the treatment is likely to extend life and under what conditions."³³ The New Jersey court, however, in *In re Conroy*,³⁴ noted that the focus should be upon the patient's "experience of pain and enjoyment [and] not the type of treatment involved."³⁵ The decisionmaker should not allow a certain treatment because it appears to be only slightly invasive of the patient's body if that treatment has little probability of ultimately returning the patient to a cognitively functioning state. Conversely, a highly invasive

³⁰ *Peter*, 108 N.J. at ___, 529 A.2d at 424.

³¹ *Cruzan ex rel. Cruzan v. Harmon* 760 S.W.2d 408, 411 (Mo. 1988) (en banc), *aff'd* *Cruzan ex rel. Cruzan v. Director, Missouri Dept. of Health*, ___ U.S. ___, 110 S. Ct. 2841 (1990).

³² *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1019, 195 Cal. Rptr. 484, 491 (1983). In *Barber*, two physicians were charged with murder and conspiracy to commit murder because they removed the patient's intravenous tubes and discontinued life-support pursuant to a request by the patient's family. *Id.* at 1010-11, 195 Cal. Rptr. at 486. The court found, *inter alia*, that the doctors' failure to continue life-sustaining treatment, although "intentional and with knowledge" of certain death for the patient, did not constitute "an unlawful failure to perform [their] legal duty." *Id.* at 1022, 195 Cal. Rptr. at 491-93.

³³ *Id.* at 1019, 195 Cal. Rptr. at 492.

³⁴ 98 N.J. 321, 486 A.2d 1209 (1985).

³⁵ *Id.* at ___, 486 A.2d at 1233. The patient, an eighty-four-year-old woman with a limited time to live, confined to bed and living in a nursing home, was both physically and mentally impaired. Her nephew, acting as guardian, sought to have her feeding tube removed. *Id.* at ___, 486 A.2d at 1216. The court continued to review the case even though Claire Conroy died before it reached the New Jersey Appellate Division. *Id.* at ___, 486 A.2d at 1219.

treatment should not be denied if it has a strong probability of aiding the patient.³⁶

Because the goal of a substitute decisionmaker is to give effect to the patient's rights, the *Conroy* court stated that the decisionmaker must base his or her decision on "at least as much medical information" as a competent person would have.³⁷ The court then suggested an extensive list of medical evidence upon which to base this decision, including:

evidence about the patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; . . . the various treatment options; and the risks, side effects, and benefits of each of these options.³⁸

The court concluded that by considering these factors the decisionmaker avoids the error of basing his conclusions on a hastily made diagnosis or prognosis.³⁹ This information will also help the decisionmaker decide whether the treatment benefits or burdens the patient and whether the patient's condition is clearly irreversible.

STANDARDS FOR APPLYING SUBSTITUTE JUDGMENT DECISIONMAKING

Substitute-Intent Standard

The substitute intent standard is the strictest of the substitute judgment standards of decisionmaking. Once the decisionmaker has examined all aspects of the patient's proposed and current medical care, he then must decide what the patient's preferences would be in the present situation.⁴⁰ In order to determine a patient's preference, the

³⁶ *Barber*, 147 Cal. App. 3d at 1019, 195 Cal. Rptr. at 491.

³⁷ *Conroy*, 98 N.J. at ___, 486 A.2d at 1231.

³⁸ *Id.* at ___, 486 A.2d at 1231.

³⁹ *Id.* at ___, 486 A.2d at 1231.

⁴⁰ *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1229 (1985).

decisionmaker must determine, as accurately as possible, the wants and needs of the incompetent individual.⁴¹ As noted by the court in *Foody*, this is an individual standard, and may not necessarily "conform to what the majority deems wise or prudent."⁴² The patient's previous statements provide the best way to judge what he would choose. The clearest evidence of this is usually a "living will" that clearly specifies the patient's wishes regarding life-sustaining treatment.⁴³ Since Virginia recognizes living wills as legally binding, such advance directives are relevant evidence of the patient's intent.⁴⁴ The New Jersey court in the case of *In re Peter* noted that the patient had executed a power of attorney authorizing a friend to make all of her health-care decisions.⁴⁵ A writing is very suggestive of an individual's "seriousness of purpose."⁴⁶ Also, a person who takes the time to set out his wishes in writing will more likely ensure that any changes are subsequently recorded.⁴⁷ According to Virginia law, however, the absence of a "living will" does not raise a presumption regarding a patient's intention with

⁴¹ *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1019, 195 Cal. Rptr. 484, 492 (1983).

⁴² *Foody*, 40 Conn. Supp. at ___, 482 A.2d at 720.

⁴³ *In re Peter*, 108 N.J. 365, ___, 529 A.2d 419, 426 (1987). A Living Will is defined as "[a] written directive by an adult patient authorizing the withholding or withdrawal of extraordinary life-sustaining procedures in the situation of terminal illness." I. SLOAN, *THE RIGHT TO DIE: LEGAL AND ETHICAL PROBLEMS* 142 (1988).

⁴⁴ See VA. CODE ANN. § 54.1-2984 (1988 & Supp. 1990); Appendix B.

⁴⁵ *Peter*, 108 N.J. at ___, 529 A.2d at 422.

⁴⁶ *In re Westchester County Medical Center, ex rel. Mary O'Connor*, 72 N.Y.2d 517, 531, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988). Mary O'Connor was an elderly, hospitalized individual, had suffered several strokes, and, as a result, was mentally incompetent and incapable of receiving nourishment without medical assistance. The hospital sought a court order permitting them to insert a nasogastric tube that was objected to by Mrs. O'Connor's daughters. *Id.* at 523-34, 531 N.E.2d at 608, 534 N.Y.S.2d at 887-88. The court ruled in favor of the hospital because there was no clear and convincing evidence that she would not want the tube inserted. *Id.* at 530-34, 531 N.E.2d at 613-15, 534 N.Y.S.2d at 892.

⁴⁷ *Id.*, 531 N.E.2d at 613-14, 534 N.Y.S.2d at 892-93.

regard to life-sustaining procedures.⁴⁸

The decisionmaker may also be guided by statements made by the patient before he became incompetent. For example, a decisionmaker may consider a patient's verbalized response to medical treatment previously administered to another.⁴⁹ In the case of *In re Jobes*,⁵⁰ the court observed that the incompetent's husband remembered his wife stating that "she would not want to be kept alive under Karen Quinlan's circumstances." She made these comments frequently in 1976 and 1977, when the Quinlan case was making news.⁵¹ However, as *Conroy* stated, "the probative value of such evidence [demonstrating intent] may vary depending on the remoteness, consistency, and thoughtfulness of the prior statements or actions and the maturity of the person at the time of the statements or acts."⁵² The court in *Cruzan v. Harmon* was reluctant to accept statements that Nancy had made to friends that if she were "sick or injured she would not want to continue [living] unless she could live 'halfway normal.'"⁵³ Regardless of the problems with a patient's prior statements, respect for patient autonomy requires that every effort be made to carry out the patient's own preferences as previously communicated.⁵⁴

⁴⁸ VA. CODE ANN. § 54.1-2986 (1988).

⁴⁹ *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1229-30 (1985).

⁵⁰ 108 N.J. 394, 529 A.2d 434 (1987).

⁵¹ *Id.* at ___, 529 A.2d at 442. Nancy Jobes was thirty-one years old and four and one-half months pregnant when she was admitted to the hospital for treatment of injuries received in a car accident. Physicians determined that the fetus had been killed. During an operation to remove the fetus, she suffered brain damage due to the loss of blood and oxygen flow to her brain. *Id.* at ___, 529 A.2d at 437. She never regained consciousness, *Id.* at ___, 529 A.2d at 438. Her husband brought an action seeking removal of the hydration and nutrition that was keeping his wife alive. *Id.* at ___, 529 A.2d at 437.

⁵² *Conroy*, 98 N.J. at ___, 486 A.2d at 1230.

⁵³ *Cruzan*, 760 S.W.2d at 411.

⁵⁴ CANTOR, *supra* note 26, at 64.

Less direct evidence of intent may also be examined, including the patient's religious beliefs, or a "consistent pattern of conduct" regarding prior medical treatment.⁵⁵

The court in *Jobes* explained that:

The surrogate considers the patient's prior statements about and reactions to medical issues, and all the facets of the patient's personality that the surrogate is familiar with - with, of course, particular reference to his or her relevant philosophical, theological, and ethical values - in order to extrapolate what course of medical treatment the patient would choose.⁵⁶

The court in *In re Quinlan* noted that Karen's father consulted with his parish priest and the hospital chaplain in order "[t]o confirm the moral rightness of the decision he was about to make" ⁵⁷ Karen's father testified that he would not have sought termination of the life support if the act conflicted with the tenets of his religion.⁵⁸ The New York court in *O'Connor* explained that the persistence, seriousness and context of the individual's statements regarding the termination of life-supports are among those factors which help convince the decisionmaker that the strength and durability of the patient's "beliefs makes a recent change of heart unlikely."⁵⁹ In this way, the decisionmaker effectively carries out the patient's wishes about medical care.

Limited-Objective Standard

The court in *Conroy* established two alternative tests under which treatment might be withheld or terminated when the medical information is insufficient or the

⁵⁵ *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1233, 1230 (1985).

⁵⁶ *Jobes*, 108 N.J. at ___, 529 A.2d at 444.

⁵⁷ *Quinlan*, 70 N.J. at ___, 355 A.2d at 658.

⁵⁸ *Id.* at ___, 355 A.2d at 658.

⁵⁹ *O'Connor*, 72 N.Y.2d at 517, 531, 531 N.E.2d at 607, 613, 534 N.Y.S.2d at 886, 892.

patient's intention is unknown: a limited-objective test and a pure-objective test.⁶⁰ The *Conroy* court characterized these tests as "best interest" tests.⁶¹ In order to withhold treatment the limited-objective test requires (1) that the decisionmaker find some "reasonably reliable evidence that [indicates] the patient would have refused the treatment if competent"⁶² . . . and (2) "that the burdens of administering the treatment outweigh the benefits of" living in the patient's present condition.⁶³ The court in *Conroy* "defined these burdens as [the] unavoidable pain and suffering that would be present throughout the remainder of the patient's life."⁶⁴

The limited-objective test requires some evidence that the patient would not have wanted the treatment or "would have wanted the treatment terminated." The criteria set out above for the subjective intent test, however, need not be satisfied.⁶⁵ That is, "[e]vidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent . . . might be sufficient to satisfy [the prong] of the limited objective test" requiring evidence that the patient would have desired termination of treatment.⁶⁶ The court in *O'Connor* noted the testimony of Mrs. O'Connor's daughter that her mother told her several times "that if she became ill and

⁶⁰ Note, *Barber v. Superior Court: Removing Food And Water From A Terminally Ill, Comatose Patient -- Who Decides?* 17 Sw. U.L. REV. 109, 126 (1987-88) [hereinafter *Who Decides*] (citing *Conroy*, 98 N.J. at ___, 486 A.2d at 1231-32).

⁶¹ *Conroy*, 98 N.J. at ___, 486 A.2d at 1231-32.

⁶² *Who Decides*, *supra* note 60, at 127.

⁶³ *Id.* at 127 (citing *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1232 (1985)).

⁶⁴ *Id.*

⁶⁵ *Conroy*, 98 N.J. at ___, 486 A.2d at 1232.

⁶⁶ *Id.* at ___, 486 A.2d at 1232.

[could not] care for herself she would not want to be sustained" by life-support.⁶⁷ This is an example of the evidence that the decisionmaker should use when applying this standard. The limited-objective standard allows for withdrawing or withholding treatment from an individual who has not sufficiently expressed any intention regarding the type of treatment to be administered when suffering would only be prolonged by the administration of such treatment.⁶⁸

Pure-Objective Standard

Conroy provided, finally, that where there is no "trustworthy evidence," or even evidence at all, that the patient would not have wanted the treatment offered, life-sustaining care may be terminated or withheld if a "pure-objective test" is met.⁶⁹ Under the pure-objective test, the burdens of the individual's life if treatment is given should "clearly and markedly" override the benefits an individual derives from living.⁷⁰ Also, where the "recurring, unavoidable and severe pain" of living with the life-sustaining treatment makes that type of treatment inhumane, it should be discontinued or withheld from the patient.⁷¹ No subjective evidence is necessary under this standard. However, if the patient had previously stated any desire to remain alive despite any suffering or pain, the treatment should continue.⁷² Because there was little or no evidence as to the pain the patient was experiencing, or would experience, or her ability to feel pleasure,

⁶⁷ *O'Connor*, 72 N.Y.2d 517, 527, 531 N.E.2d 607, 611, 534 N.Y.S.2d 886, 890.

⁶⁸ *Who Decides*, *supra* note 60, at 127.

⁶⁹ *Conroy*, 98 N.J. at ___, 486 A.2d at 1232.

⁷⁰ *Id.* at ___, 486 A.2d at 1232.

⁷¹ *Id.* at ___, 486 A.2d at 1232.

⁷² *Id.* at ___, 486 A.2d at 1232.

the court in *Conroy* refused to apply even this standard.⁷³

SUMMARY OF EVIDENTIARY REQUIREMENTS

In summarizing the evidence that requires consideration in determining whether one of the three standards -- substitute-intent, limited-objective or pure-objective -- may be utilized by a substitute decisionmaker, the concurring opinion in *O'Connor* provided the seven most significant factors:

(1) the intention of the patient under the existing circumstances, to whatever extent it can be ascertained from past expressions; (2) any moral, ethical, religious or other deeply held belief, insofar as it might bear on the patient's probable inclinations in the matter; (3) the medical condition of the patient, including the level of mental and physical functioning and the degree of pain and discomfort; (4) the nature of the prescribed medical assistance, including its benefits, risks, invasiveness, painfulness, and side effects; (5) the prognoses with and without the medical assistance, including life expectancy, suffering and possibility of recovery; (6) the sentiments of the family or intimate friend; and (7) the professional judgment of the involved physicians.⁷⁴

When the decisionmaker has applied the above standards, he must then be "manifestly satisfied" that the facts support the use of one of the substitute intent/best interest tests.⁷⁵ However, if a petition is brought to a Virginia Circuit Court regarding the decision that has been reached, the court may "enjoin such action upon finding by a preponderance of the evidence that the action is not lawfully authorized by this section and that the action is not otherwise authorized by state or federal law."⁷⁶ Therefore, the decision is not free of judicial review if there is disagreement over a choice of

⁷³ *Conroy*, 98 N.J. at ___, 486 A.2d at 1243.

⁷⁴ *O'Connor*, 72 N.Y.2d 517, 537, 531 N.E.2d 607, 617, 534 N.Y.S.2d 886, 896 (1988) (emphasis in original).

⁷⁵ *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1233 (1985). The *Conroy* court analogized to *In re Grady*, 85 N.J. 235, ___, 426 A.2d 467, 483 (1981), where the court required a clear and convincing standard before approval for the sterilization of a mentally retarded, incompetent adult.

⁷⁶ V.A. CODE ANN. § 37.1-134.4(F) (Supp. 1990).

treatment. This should ease the minds of those who fear unfettered decisionmaking resulting in active or passive euthanasia.⁷⁷

In closing, the court in *Conroy* issued a cautionary note to those trying to implement one of the three standards:

it will frequently be difficult to conclude that the evidence is sufficient to justify termination of treatment under either of the "best interests" tests. . . . Often, it is unclear whether and to what extent a patient . . . is capable of, or is in fact, experiencing pain. Similarly, medical experts are often unable to determine with any degree of certainty the extent of a nonverbal person's intellectual functioning or the depth of his emotional life. When the evidence is insufficient to satisfy either the limited-objective or pure-objective standard, however, we cannot justify the termination of life-sustaining treatment as clearly furthering the best interests of . . . [the] patient.⁷⁸

The court based this final conclusion on the presumption 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."⁷⁹ This statement of public policy ties into the state interests discussed in the following section. The line between the three tests is not always clear, nor is the line between the interests of the individuals and those of the state. However, this may be advantageous because the lines change as the facts change, therefore providing for specific decisions for specific individuals rather than static rules.

STATE INTERESTS

The three standards providing guidance to a health-care decisionmaker for an incompetent adult focus almost entirely on the individual. These standards must therefore be balanced against five state interests: (1) preserving life, (2) protecting innocent third parties, (3) preventing suicide, (4) maintaining the "ethical integrity" of

⁷⁷ B. HASFORD, MAKING YOUR MEDICAL DECISIONS 17-18 (1982).

⁷⁸ *Conroy*, 98 N.J. at ___, 486 A.2d at 1233.

⁷⁹ *Id.* at ___, 486 A.2d at 1233.

the medical profession,⁸⁰ and (5) the costs of medical care. As the *Conroy* court recognized, the state's interest in preserving life is often considered the most significant of the five interests.⁸¹ This interest embraces two separate but related concerns: an interest in preserving the patient's life and an interest in preserving the sanctity of all life.⁸² However, as the dissent in *Cruzan* noted, the state recognizes a "relativity of values" concerning life because it often carries out capital punishment and it often recognizes the "[l]iving [w]ill" which "allows and encourages the pre-planned termination of life"⁸³ Also, as the court in *Quinlan* observed, the state's interest in preserving life is neither static nor absolute. The state interest "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."⁸⁴ Ultimately there is a point where the privacy right of the individual overcomes the interest of the state.⁸⁵ The state interest in preserving life extends to the protection of innocent third parties.⁸⁶ The patient's rights "must frequently give way," as noted in *Conroy*, where the exercise of "his choice could adversely and directly affect the health, safety, or security of others"⁸⁷

Third, the state has an interest in preventing suicide. However, as the court in

⁸⁰ Buchanan, *The Limits of Proxy Decisionmaking For Incompetents*, 29 UCLA L. REV. 390-91 (1981). See also *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, ___, 482 A.2d 713, 718 (1984); *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1233 (1985).

⁸¹ *Conroy*, 98 N.J. at ___, 486 A.2d at 1233.

⁸² *Cruzan, ex rel. Cruzan by Harmon*, 760 S.W.2d 408, 419 (Mo. 1988) (en banc), *aff'd Cruzan ex rel. Cruzan v. Director, Missouri Dept. of Health*, ___ U.S. ___, 110 S. Ct. 2841 (1990).

⁸³ *Id.* at 428-29 (Blackmar, J., dissenting).

⁸⁴ *In re Quinlan*, 70 N.J. 10, ___, 355 A.2d 647, 664 (1976).

⁸⁵ *Id.* at ___, 355 A.2d at 664.

⁸⁶ *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1225 (1985).

⁸⁷ *Id.* at ___, 486 A.2d at 1225.

Foody explained, the cessation of medical treatment does not constitute suicide because "(1) in refusing treatment the patient may not have the specific intent to die and (2) even if he did, to the extent that death resulted from natural causes, the patient did not set the death producing agent in motion with intent to cause his own death."⁸⁸ The traditional definition of suicide is "self-destruction" or "the deliberate termination of one's own life."⁸⁹ The actions in these cases clearly do not fall within this definition.

The fourth state interest concerns safeguarding the integrity of the medical profession. However, as the *Conroy* court noted, medical ethics have never required "medical intervention in disease at all costs."⁹⁰ The terms "ordinary" and "extraordinary" care have previously been used in deciding whether to terminate "life-sustaining" treatment.⁹¹ Under this distinction, ordinary care is obligatory and extraordinary care is optional. The court in *Foody* defined these terms:

Ordinary means are all medicines, treatments and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain or other inconvenience. Extraordinary means are all medicines, treatments and operations which cannot be obtained or used without excessive expense, pain or other inconvenience, or if used, would not offer a reasonable hope of benefit.⁹²

Therefore, the court concluded that the right to refuse treatment in appropriate circumstances is consistent with existing medical mores.⁹³ In fact, surveys have recently noted that the majority of physicians approve of "passive euthanasia" and believe that

⁸⁸ *Foody*, 40 Conn. Supp. at ___, 482 A.2d at 720.

⁸⁹ BLACK'S LAW DICTIONARY 1434 (6th ed. 1990).

⁹⁰ *Conroy*, 98 N.J. at ___, 486 A.2d at 1224.

⁹¹ *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, ___, 482 A.2d 713, 719 (1984).

⁹² *Id.* at ___, 482 A.2d at 719 (quoting KELLY, MEDICO-MORAL PROBLEMS 129 (1959)).

⁹³ *Id.* at ___, 482 A.2d at 720.

their colleagues are practicing it.⁹⁴ As noted in several decisions, where there is no "bad faith," doctors will not be held criminally or civilly liable for carrying out the decision of a substitute decisionmaker.⁹⁵

One additional societal interest, the cost of medical care, actually supports withholding treatment. Today, some ten-thousand people remain in a persistent vegetative state. A million and a half more suffer from "severe dementia," and, by the year 2000, the number of those with the disease is expected to rise by sixty percent.⁹⁶ Also, a Harvard Medical School report found that there are close to four million more suffering from Alzheimer's disease.⁹⁷ The money that it costs this country to care for the ten thousand patients in a vegetative state could be used for patients who have some hope of improving.

The care for Nancy Cruzan alone costs a hundred and thirty thousand dollars a year. Her family doesn't pay; the State of Missouri and social security cover her bills.⁹⁸ Her own medical insurance has been exhausted since 1986.⁹⁹ The dissent in *Cruzan* noted that many people die because they cannot afford medical care, and the state has no desire to help them pay.¹⁰⁰ And yet, the State of Missouri appears

⁹⁴ *In re Conroy*, 98 N.J. 321, ___, 486 A.2d 1209, 1225 (1985).

⁹⁵ *Id.* at ___, 486 A.2d at 1242. *See also* John F. Kennedy Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984); *In re Quinlan*, 70 N.J. 10, ___, 355 A.2d 647, 666-669 (1976). *See generally* Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

⁹⁶ Hentoff, *Does a Loving Family Have the Right to Kill?*, VILLAGE VOICE, Dec. 26, 1989, at 20, col. 2.

⁹⁷ *Id.*

⁹⁸ *Id.* at 20, col. 1. *See also* *Cruzan*, 760 S.W.2d 408, 427, 429 (Mo. 1988) (en banc) (Blackmar, J., dissenting); *id.* at 432 (Higgins, J., dissenting).

⁹⁹ *Cruzan*, 760 S.W.2d at 432 (Higgins, J., dissenting).

¹⁰⁰ *Id.* at 429 (Blackmar, J., dissenting).

determined to keep Nancy Cruzan alive for as long as thirty years.¹⁰¹ No wonder Joyce Cruzan, Nancy's mother, remains bewildered by the State's unbending position. Joyce Cruzan recently said: "She [Nancy] would not want that, and yet somebody out there says, 'It doesn't matter what she wants. It doesn't matter what you want as her family. The state says life is precious. Therefore, it doesn't matter what you want. It doesn't matter at all. Nancy doesn't matter.'"¹⁰² However, what Virginia must recognize is that valuable medical resources are dwindling and difficult choices about who should receive what care must be made.

CONCLUSION

The standards of substitute judgment set forth above should help to balance the competing interests of individual privacy rights, state interests, and health care costs. The decisions of other state courts provide the support necessary to fully implement the Virginia statute approving surrogate decisionmaking. These decisions also give credence to the fact that Virginia has provided a workable set of standards. Although the decisions about medical care for incompetents will continue to be difficult at best, the Virginia legislature has removed a substantial amount of the uncertainty about who should make treatment decisions in the case of formerly competent adults.

In the end, the *Quinlan* court gave perhaps the best reason for implementing the doctrine of substitute judgment: "We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-

¹⁰¹ *Id.* at 411.

¹⁰² Hentoff, *supra* note 96 at 20, col. 1.

support apparatus, even if it meant the prospect of natural death."¹⁰³

¹⁰³ *Quinlan*, 70 N.J. at ___, 355 A.2d at 663.

APPENDIX A

VA. CODE ANN. § 37.1-134.4 (Supp. 1990) provides:

§ 37.1-134.4. Authorization for providing, withholding, or withdrawing treatment for certain persons; persons who may authorize exclusions; applicability restricted to nonprotesting patients. --- A. The procedures for surrogate treatment decision-making specified in this section shall be available as an alternative to other statutory and common law authority for making medical decisions on behalf of adult persons unable to make informed decisions, and health care providers may, but need not, invoke the procedures authorized herein. This section shall not affect the law defining the conditions under which consent must be obtained for medical treatment, or the nature of the consent required.

B. Whenever a licensed physician determines after personal examination that an adult person, because of mental illness, mental retardation, or any other mental disorder, or a physical disorder which precludes communication or impairs judgment, is incapable of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of treatment, the physician may, upon compliance with the provisions of the section, provide to, withhold, or withdraw from the person that treatment upon the authorization of any of the following persons, in the specified order of priority, if the physician is not aware of any available person in a higher class: (i) a person designated in a writing executed pursuant to § 54.1-2984, if given such authority in the writing; (ii) a guardian or committee currently authorized to make such decisions; (iii) an attorney-in-fact appointed under a durable power of attorney, to the extent the power grants the authority to make such a decision, provided that the attorney-in-fact is not employed by the physician or the organization employing the physician; (iv) the spouse; (v) an adult son or daughter; (vi) a parent; (vii) an adult brother or sister; or (viii) any other relative of the person in the descending order of blood relationship. For the purposes of the section, the durable power of attorney may provide that it is effective during or only during a period in which the principal, because of a physical or mental disability, as determined by the provider of that treatment. For purposes of this section, "incapable of making an informed decision" means unable to understand the nature, extent or probable consequences of a proposed medical decision, or unable to make a rational evaluation of the risks and benefits of the proposed decision as compared with the risks and benefits of alternatives to that decision. For purposes of this section, persons who are deaf, dysphasic or have other communication disorders but who are otherwise mentally competent and able to communicate by means other than speech shall not be considered incapable of giving informed consent.

C. The provisions of this section shall not apply to authorize nontherapeutic sterilization, abortion, psychosurgery, or admission to a mental retardation facility or psychiatric hospital, as defined in § 37.1-1; however, the provisions of this section, if otherwise applicable, may be employed to authorize a specific treatment or course of treatment for a person who has been lawfully admitted to such a facility.

D. The provisions of the section shall not authorize providing, continuing to provide, withholding or withdrawing of treatment if the provider of the treatment knows or upon reasonable inquiry ought to know that such an action is protested by the person. No person enumerated in subsection B of this section shall authorize, pursuant to this section, treatment, or a course of treatment, that such person knows, or upon reasonable inquiry ought to know, is contrary to the religious beliefs or basic values of the person unable to make

a decision, whether expressed orally or in writing.

E. Prior to the initiation or cessation of treatment for which authorization has been obtained or will be sought pursuant to this section, and no less frequently than every 180 days while the treatment continues, the physician shall obtain a written certification that the person is incapable of making an informed decision regarding the treatment. This certification shall be made by a licensed physician or licensed clinical psychologist who is not otherwise currently involved in the treatment of the person assessed and shall be based on a personal examination of the person. The cost of the assessment shall be considered for all purposes a cost of the treatment provided.

F. On petition of any person to the circuit court of the county or city in which resides or is located any person for whom treatment will be or is currently being provided, withheld or withdrawn under the purported authority of this section, the court may enjoin such action upon finding by a preponderance of the evidence that the action is not lawfully authorized by this section and that the action is not otherwise authorized by state or federal law.

G. No person or facility providing, withholding or withdrawing treatment pursuant to the authorization obtained pursuant to this section shall incur liability arising out of a claim to the extent the claim is based on lack of consent or authorization for such action.

H. No person authorizing treatment pursuant to this section shall be liable for the cost of treatment solely on the basis of that authorization. No person giving authorization pursuant to this section shall incur liability arising out of a claim of breach of duty to the person receiving treatment, provided that the person giving consent (i) prior to giving consent, makes a good faith effort to ascertain the risks and benefits of and alternatives to the treatment and the religious beliefs and basic values of the person receiving treatment, and to inform the person, to the extent possible, of the proposed treatment and the fact that someone else is authorized to make a decision regarding that treatment; and (ii) bases his decision on the best interest of the person, taking into account the person's religious beliefs and basic values and any preferences previously expressed by the person regarding such treatment.

I. Nothing in this section shall be deemed to affect the right to use, and the authority conferred by, any other applicable statutory or regulatory procedure relating to the authorization of providing, withholding or withdrawing treatment, or to diminish any common law authority of a physician to provide, withhold, or withdraw treatment to a person unable to make an informed decision about the providing, withholding or withdrawing of that treatment, with or without the consent of the person's relative.

APPENDIX B

Virginia does not provide a form for executing a Durable Power of Attorney For Health Care. However, D.C. CODE ANN. §§ 21-2205 to -2209 (1989) provides a sample draft of a Health Care Power of Attorney.

§ 21-2205. Durable power of attorney for health care.

(a) A competent adult may designate, in writing, an individual who shall be empowered to make health-care decisions on behalf of the competent adult, if the competent adult becomes incapable, by reason of mental disability, of making or communicating a choice regarding a particular health-care decision.

(b) A durable power of attorney for health care shall include language which clearly communicates that the principal intends the attorney in fact to have the authority to make health-care decisions on behalf of the principal and shall include language identical or substantially similar to the following:

- (1) "This power of attorney shall not be affected by the subsequent incapacity of the principal."; or
- (2) "This power of attorney becomes effective upon the incapacity of the principal."

(c) A durable power of attorney for health care shall be dated and signed by the principal and 2 adult witnesses who affirm that the principal was of sound mind and free from duress at the time of signing. The 2 adult witnesses shall not include the principal, the health-care provider of the principal or an employee of the health-care provider of the principal.

(d) Of the 2 adult witnesses referred to in § 21-2204(c), at least 1 shall not be related to the principal by blood, marriage or adoption and shall not be entitled to any part of the estate of the principal by a current will or operation of law.

(e) Any durable power of attorney executed . . . and specifically written to include health-care decision making after incompetency shall be effective, if the execution of the prior document meets the requirements of this chapter.

§ 21-2206. Rights and duties of attorney in fact.

(a) Subject to any express limitations in the durable power of attorney for health care, an attorney in fact shall have all the rights, powers and authority related to health-care decisions that the principal would have under District and federal law. This authority shall include, at a minimum:

- (1) The authority to grant, refuse or withdraw consent to the provision of any health-care service, treatment, or procedure;
- (2) The right to review the health care records of the principal;
- (3) The right to be provided with all information necessary to make informed health-care decisions;

- (4) The authority to select and discharge health-care professionals;
and
- (5) The authority to make decisions regarding admission to or discharge from health-care facilities and to take any lawful actions that may be necessary to carry out these decisions.
- (b) (1) Except as provided in paragraph (2) of this subsection and unless a durable power of attorney for health care provides otherwise, the designated attorney in fact, if known to a health-care provider to be available and willing to make a particular health-care decision, shall have priority over any other person to act for the principal in all matters regarding health care.
 - (2) A designated attorney in fact shall not have the authority to make a particular health-care decision, if the principal is able to give or withhold informed consent with respect to that decision.
- (c) In exercising authority under a durable power of attorney for health care, the attorney in fact shall have a duty to act in accordance with:
 - (1) The wishes of the principal as expressed in the durable power of attorney for health care; or
 - (2) The good faith belief of the attorney in fact as to the best interests of the principal, if the wishes of the principal are unknown and cannot be ascertained.
- (d) Nothing in this chapter shall affect any right that an attorney in fact may have, independent of the designation in a durable power of attorney for health care, to make or otherwise participate in health-care decisions on behalf of the principal.

§ 21-2207. Forms for creating a durable power of attorney for health care.

Any written form meeting the requirements of § 21-2205 may be used to create a durable power of attorney for health care. The following is offered as a sample form only and its inclusion in this section shall not be construed to preclude the use of alternative language:

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, IT IS VITAL FOR YOU TO KNOW AND UNDERSTAND THESE FACTS:

THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR ATTORNEY IN FACT THE POWER TO MAKE HEALTH-CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISIONS FOR YOURSELF.

AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH-CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. IN ADDITION, AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

YOU MAY STATE IN THIS DOCUMENT ANY TYPE OF TREATMENT THAT YOU DO NOT DESIRE AND ANY THAT YOU WANT TO MAKE SURE YOU RECEIVE.

YOU HAVE THE RIGHT TO TAKE AWAY THE AUTHORITY OF YOUR ATTORNEY IN FACT, UNLESS YOU HAVE BEEN ADJUDICATED INCOMPETENT, BY NOTIFYING YOUR ATTORNEY IN FACT OR HEALTH-CARE PROVIDER EITHER ORALLY OR IN WRITING. SHOULD YOU REVOKE THE AUTHORITY OF YOUR ATTORNEY IN FACT, IT IS ADVISABLE TO REVOKE IN WRITING AND TO PLACE COPIES OF THE REVOCATION WHEREVER THIS DOCUMENT IS LOCATED.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

* * * * *

YOU SHOULD KEEP A COPY OF THIS DOCUMENT AFTER YOU HAVE SIGNED IT. GIVE A COPY TO THE PERSON YOU NAME AS YOUR ATTORNEY IN FACT. IF YOU ARE IN A HEALTH-CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint:

_____ name _____ home address

_____ home telephone number _____

_____ work telephone number _____

as my attorney in fact to make health-care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person to serve in the order listed below:

1. _____
name home address

home telephone number

work telephone number

2. _____
name home address

home telephone number

work telephone number

With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below or as I make known to my attorney in fact in some other way.

(a) STATEMENT OF DIRECTIVES CONCERNING LIFE-PROLONGING CARE, TREATMENT, SERVICES, AND PROCEDURES:

(b) SPECIAL PROVISIONS AND LIMITATIONS:

BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this form on _____
(date)

at: _____
_____ (address).

(Signature)

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the attorney in fact by this document, nor am I the health-care provider of the principal or an employee of the health-care provider of the principal.

First Witness

Signature: _____
Home Address: _____
Print Name: _____
Date: _____

Second Witness

Signature: _____
Home Address: _____
Print Name: _____
Date: _____

(AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

Signature: _____
Signature: _____

§ 21-2208. Revocation.

(a) At any time that the principal has the capacity to create a durable power of attorney for health care, the principal may:

- (1) Revoke the appointment of the attorney in fact under a durable power of attorney for health care by notifying the attorney in fact orally or in writing; or
- (2) Revoke the authority to make health-care decisions granted to the attorney in fact under a durable power of attorney for health care by notifying the health-care provider orally or in writing.

(b) If a health-care provider is notified of a revocation pursuant to subsection (a)(2) of this section, the health-care provider shall document this fact in the patient-care records of the principal and make a reasonable effort to notify the attorney in fact of the revocation.

(c) There shall be a rebuttable presumption, affecting the burden of proof, that a principal has the capacity to revoke a durable power of attorney for health care.

(d) Unless it expressly provides otherwise, a valid durable power of attorney for health care revokes any prior durable power of attorney for health-care decisions only.

(e) Unless a durable power of attorney for health care expressly provides otherwise, and after its execution the marriage of the principal is dissolved or annulled, the dissolution or annulment shall automatically revoke a designation of the former spouse as an attorney in fact to make health-care decisions for the principal. If a designation is revoked solely on account of this subsection, it shall be revived by the remarriage of the principal to the former spouse but may be subsequently revoked by an act of the principal.

§ 21-2209. Health-care provider limitation.

(a) No health-care provider may require an individual to execute a durable power of attorney for health care as a condition for the provision of health-care services or admission to a health-care facility, as defined in Statute 32-1301.

(b) After an individual has spent at least 48 hours in a health care facility, a health care provider may request the individual to execute a durable power of attorney for health care subject to the limitations set forth in this chapter. The health care provider may not be named as the attorney in fact.

APPENDIX C

VIRGINIA LIVING WILL STATUTE

VA. CODE ANN. § 54.1-2984 (Supp. 1990).

Suggested form of written declaration. -- A declaration executed pursuant to this article may, but need not, be in one of the following forms, 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 and do hereby declare:

CHOOSE ONLY ONE OF THE NEXT TWO PARAGRAPHS AND CROSS THROUGH THE OTHER

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, my death is imminent, and I am comatose, incompetent or otherwise mentally or physically incapable of communication, I designate _____ to make a decision on my behalf as to whether life prolonging procedures shall be withheld or withdrawn. In the event that my designee decides that such procedures should be withheld or withdrawn, I wish to 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.

OR

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.