

April 2017

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### Recommended Citation

Nicholas A. Spinella (1978) "Death with Dignity Legislation," *The Catholic Lawyer*. Vol. 23 : No. 3 , Article 6.  
Available at: <https://scholarship.law.stjohns.edu/tcl/vol23/iss3/6>

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# DEATH WITH DIGNITY LEGISLATION

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*"No man's life, liberty, or property are safe while the legislature is in session."*

This quotation, taken from an 1866 New York court decision, warns us all to be vigilant during legislative sessions. Our particular subject today, death with dignity legislation, brings into sharp focus our growing concern for the preservation of our right to life. Powerful forces are trying to legalize euthanasia, the "mercy killing" of the elderly, the ill, the handicapped and the unwanted.

The distribution of thousands of copies of so-called "living wills," the introduction of death with dignity bills in many states, and the recent passage of the California Natural Death Act, leaves little cause for complacency among those of us who presently find themselves somewhere between infancy and senility.

The Director of the Center for Death Education and Research said at a public seminar on January 19, 1972, that "[t]he practice of mercy killing may be commonly accepted by American society within the next decade." The Euthanasia Education Council, founded in 1967, has promoted legislation seeking to codify into law the concept of a "living will" by means of which a person, while of sound mind, can signify his wishes to those concerned with his terminal illness. Such legislation is generally referred to as death with dignity legislation.

The recent decision of the Supreme Court of New Jersey in the Karen Ann Quinlan case received extensive press coverage and focused the attention of the American public on the legal definition of death. At first, the case appeared to be the classic one in which natural death had, in fact, occurred; but as the case progressed, it became clear that death had not yet, in fact, occurred and that death with dignity was the real issue, since all of the parties agreed that under any legal definition of death, Karen was still alive.

Until recently, death was identified with the cessation of blood circulation and respiration. With the advent of organ transplantation, however, at least twelve states, including the state of Virginia, have adopted legislation for the general purpose of recognizing the use of brain death as a criteria for the legal determination of death. The criteria generally are as follows:

1. The patient shows no response or awareness to external stimulation. Even painful stimuli cause no vocal or physical response.
2. Under close observation, for at least one hour, the patient does not move or breathe spontaneously.
3. There are no bodily reflexes to indicate central nervous system activity. The pupils of the eyes are fixed and dilated.
4. There is a flat electroencephalogram (E.E.G.).

These tests must be repeated at least twice, twenty-four hours apart. If there is no change, brain death has legally occurred.

Karen Ann Quinlan did not meet the criteria for brain death, made obvious by the fact that she continues to live today, almost one year after she was taken off the respirator by court order and transferred to a nursing home, where no extraordinary means for keeping her alive have been allowed.

The Quinlan decision viewed the right to privacy of the individual (more properly termed the right to refuse treatment) to be superior to society's right to protect the lives of its members, in her particular case of terminal illness. It would appear, therefore, that the decision will be of little direct assistance to the resolution of questions presented by terminal illness situations generally.

The media coverage of the Quinlan case did, however, result in much public discussion of the "right to die" issue and, unfortunately, has caused many legislators to attempt solution of this very complex medical-moral issue by legislation which in the state of California has been enacted into law.

Between January 1, 1977, and March 1, 1977, there have been forty-nine so-called "death with dignity," "right to die" or "natural death" bills introduced in thirty-six states. Twenty-three of these bills are identical or similar to the California Natural Death Act enacted in September, 1976.

Death with dignity legislation was introduced in the Virginia General Assembly in 1975 and 1976 and was defeated in committee because of strong opposition from the Diocese of Richmond and the Virginia Medical Society. We were successful in convincing the Medical Society of Virginia, representing 4,500 doctors, that legislation would interfere with the physician-patient relationship and that decisions to withdraw extraordinary treatment should be made by the patient, family, physician and minister. However, a study resolution was adopted by the 1977 session of the Virginia legislature assuring introduction of a new bill in 1978 and a continuation of our legislative battle against proponents of such laws in Virginia.

Care must be taken to clearly point out the fact that our opposition is not to the concept of death with dignity, but rather to legislation on that subject. In opposing death with dignity legislation, we are not opposing the individual's right to approach death in a dignified manner without unnecessary suffering or emotional or financial hardship. Such legislation does not resolve or "make easy" the prognosis of terminal illness or the medical

decision to cease the use of life-sustaining procedures which serve only to artificially prolong the moment of death during terminal illness.

As attorney for the Diocese of Richmond and for St. Mary's Hospital, I voiced serious legal objections to these bills. Such laws are not only unnecessary, but also dangerous because they will do more harm than good. Such legislation interferes with the doctor-patient relationship and creates additional legal problems for physicians in the midst of a medical malpractice crisis.

Legislation is not necessary because no present federal or state law requires that heroic or extraordinary measures be taken to sustain life in the event of terminal illness or injury. The decision not to use extraordinary or heroic measures to sustain life is made daily by patients, their families and attending physicians in individual cases, privately and in a dignified manner and in compliance with good medical practice and the common law of our country. Legislation will only serve to complicate these highly personal decisions. Such legislation is not necessary to protect patients since they already have the right to refuse the administration of drugs or medical treatment which right of refusal is absolute and legally binding on the physician.

Most, if not all, attorneys would agree that it is virtually impossible to legislatively define terms such as "terminal illness" and "extraordinary or heroic medical treatment" and, as a matter of fact, it may not be possible to linguistically define such terms.

These bills give statutory approval to a so-called "living will" when there is no such thing as a "living will" in our law. It is not a will at all. It's more like a power of attorney or a contract for medical service with a condition terminating or limiting said service under certain conditions and circumstances. It would appear that a refusal of treatment needs to be based on information of the type necessary to support an informed consent for treatment. Can a "living will," executed perhaps years prior to terminal illness, without the benefit of all the facts and circumstances of such illness or injury, meet the legal test of informed consent to the cessation of treatment by the patient? I seriously doubt it. Without informed consent from the patient, a malpractice judgment against the physician is virtually assured.

What about the patient who never makes a "living will?" In my opinion, this legislation would expose the attending physician and the hospital to malpractice liability, unless all available extraordinary means to sustain life are used if the patient's "living will" is not in the doctor's file or the hospital's medical record. The bill therefore, instead of giving the physician malpractice immunity, creates malpractice liability not found under present laws.

The doctor must decide legal questions concerning the validity of a written "living will" or previous oral requests of his patient. He must decide if such will is still in effect or whether it has been modified or revoked and he is given immunity from liability only if he decides those

legal questions correctly and, in addition, follows the standard of care for treatment of terminally ill patients.

Malpractice lawyers will welcome such legislation because it will foster litigation and provide malpractice claims where none existed previously. Malpractice insurance premiums, already extremely high, will go higher and those premiums must be passed on to the patient, thereby again increasing the cost of medical care.

As seriously as these legal concerns are in opposition to death with dignity legislation, they are secondary to the much greater concern that such laws provide a first step to euthanasia legislation in the United States. The legality of the "living will" is the first objective of euthanasia proponents and the next legislative step from passive to active euthanasia becomes easier and more acceptable. Such legislation will result in an increased disregard for the terminally ill, the elderly and the non-productive citizens of our country. I, for one, am not willing to relieve the physician from all legal responsibility for properly making the ultimate medical decision regarding the termination of treatment designed solely to sustain the life or life processes. He is fully protected under the common law today when that decision is reached in consultation with the patient or his family. Physicians should be urged to take responsibility for their actions, together with the family or individual responsible to the patient.

The nonprolongation of death, while respecting the sanctity of life, is certainly one of the most difficult problems faced by physicians and other health care personnel today. Death with dignity legislation, however, does not make these decisions easy, but rather complicates them. If the patient is conscious, the patient must be the one to consent to the cessation of treatment. If he is unconscious, the family, with proper moral guidance, must be included in the discussions before the decision is reached. In the end, however, the responsibility for the decision must remain with the physician caring for the patient. At no time in these considerations should the concerns of the dying patient be disregarded.

Death with dignity is available today without the necessity of checking out the legality of a "living will" or calling lawyers to the hospital. Death is a very personal matter between parents and children, husbands and wives and between God and dying patients. It is not the business of the legislature or the courts.

The right to life predates the Constitution and received recognition in the Declaration of Independence as an "inalienable" freedom. Until the Supreme Court's abortion decision, our laws approved only a few instances in which the taking of human life is permissible and even these have come into serious question. In this context, we must seriously oppose death with dignity legislation which will lead inevitably toward euthanasia.

As diocesan attorneys, it is your responsibility to give advice and counsel to your diocese concerning the legal pitfalls of death with dignity laws and you should participate fully in legislative hearings and public debate in your community concerning the necessity or advisability of such

proposals. Coordinated action taken by the moral, medical and legal segments of your community can successfully defeat such legislation. Opposition organized by church leaders, physicians and attorneys has proven effective in Virginia and Maryland, but we must all remain alert and involved while the legislatures continue to meet—since your right to live may be the issue.

#### QUESTIONS TO NICHOLAS SPINELLA

DICK TAYLOR:

This is more of an observation. We are right in the midst of a legislative fight. We have lost it in the House, and it appears we will be successful in the Senate. They may have voted while I have been out of town. I wanted to point out a couple of things, and these will not be new to the Bishop or Mr. Spinella. First of all, all of a sudden something that may not have been dealt with for years, Euthanasia, Incorporated suddenly becomes Death with Dignity, Incorporated. No change of personnel at all. And when the bill comes in it is almost without fail a copy of the California bill, except, and I'm not sure whether this was in the California bill, the bill contains a malpractice feature that immediately attracts your doctor's attention. Our bill provides that there will be no malpractice cases against any physician acting in conformance with this act. Some lawyers question the constitutionality of cutting off a person's right of action. But it is a very important part of the bill.

Another point, Dr. McCarthy Demere from Memphis, I'm sure these gentlemen know him, had the advantage of being both a physician and an attorney and has spoken in many, many states against this bill very impressively. If we beat it in the Senate, which I think we have, it was only with the doctors' association, the Tennessee Medical Association. You can't beat it without it. It just can't be done.

A couple of points that did come up. Malpractice has been mentioned and it impressed the lawyers and the legislature, and maybe yours is very similar to ours and still made up of a majority of lawyers. To my knowledge there has never been a single malpractice claim or criminal prosecution against any doctor in this country in connection with this, with failure or with cutting off extraordinary means. This bill is completely unnecessary. But the one thing that we presented, that I think impressed some of the lawyers is this: if this "living will" bill is enacted in your state or my state, it suddenly says that with this you will have to do this, this and this. And you and I, as lawyers, know that the majority of people still are not going to run out and execute these wills. The vast majority of people do not have what I call "real wills" as opposed to this, or a power of attorney. But the very fact that the vast majority of people are going to be brought into our hospitals, the doctor's hands and the family's hands would forever be tied because if they do not have a "living will" then that will evidence an intent on their part not to stop extraordinary means. And that would be, I think,

the legal interpretation it has received. The same arguments are coming up in each state, but I think as the states face them they will add to their bonfire, so to speak, and we have got to be ready to meet it. Thank you.

JOHN MARKET:

Nick, you mentioned that you have a brain death statute in Virginia, if I'm not mistaken.

SPINELLA:

Yes.

QUESTION:

Now, we have had both the "living will" and the brain death statute in Minnesota. Our "living will" is dead for the moment. Don't you see the brain death statute as an entry of the legislature into the death-defining business? We have resisted in Minnesota the brain death statute as a medical concept or as a valid concept for defining death for the medical professional. Our testimony to the legislature has been that we don't think the legislature should legislate in any way, shape or form on the subject of death-defining. Who is to say that if they can say that you're dead if your brain is dead, why can't they say you're dead when your little toe is dead, or when your kidneys are dead? Do you see that as an entry into euthanasia in the death-defining business?

SPINELLA:

No, personally I do not. I don't see that really as being a first step to a "living will" statute. We have had the brain death statute in Virginia for years; I guess we were one of the first states to pass it as part of our Uniform Anatomical Gift Act. It was passed in order to allow heart transplants at our Medical College of Virginia in Richmond and it passed in that context. I do not think that a brain death statute is necessarily bad law. I realize that there has been a very strong reaction on the part of many dioceses throughout the country to resist a brain death statute. I do not feel that that is where the battle should be fought. I believe really that you are kind of missing the boat if you fight it there, because I think medically, brain death legislation is certainly justifiable. Perhaps Bishop Sullivan would comment on this as I have not discussed it with him. But I do not think there is any problem today with our brain death statute, from a moral standpoint. I realize that opinions can differ on this, but I would not fight the battle there. I do not think that this is the same thing at all as the Death with Dignity Bill.

In Virginia this has not been a problem, but I am not sure this is not a problem elsewhere. The reason I say this is because I attended a seminar cosponsored by Georgetown University and one of the talks given there was

by a professor of the Harvard Divinity School on the criteria for determining death. He had this basic philosophy. He said, "Provided we can sustain the slippery slope theory," in other words, if we could stop at this level, he would like to see death defined as the cessation of the higher brain faculties. My response to that was, "There are a lot of walking dead." I think the problem might be what others are saying about death.

EDWARD MCGINNESS:

One comment on the definition of death statutes. In our state, death with dignity and definition of death passed through an Anatomical Gift Act, were presented as a two-bill package to the legislature. Both were defeated. The main objection to the definition of death statute was that it was also unnecessary. The definition of death statute requires that the physician make the judgment. In the best judgment of the physician, has brain activity ceased to a certain degree? It required the physician to look at the brain wave charts, to look at the various criteria listed to determine if you have the cessation of brain function. Then the physician in his best judgment as the physician can make the call and say, "This person is dead; let's take the kidney or the heart out." But the physician can do that now, without any legislation. The physician is empowered to declare a person dead, basing his judgment on various criteria which includes heart rate, respiration, brain waves, etc. Once you define and limit him by some certain criteria, you are making it more difficult for the physician, and you are also complicating a situation that does not need to be complicated because a physician already has the power to declare a person dead in his best medical judgment based on the criteria available to him. So I would think that, for the same reason you would oppose a death with dignity bill as being unnecessary intrusion into a very complex medical field, you should also oppose the definition of death statute because it also requires the physician to make a judgment which he already makes. Thank you very much.

QUESTION:

At the expense of not ingratiating myself with the distinguished panel, I would like to make an observation and ask a question. It has been said by both speakers that the ultimate decision to receive medical treatment in the final analysis rests with the patient. And I certainly subscribe to that. I would like to ask a question, however. Let's assume, hypothetically, that Patient A, like Patient B, both have the same medical problem. Let's assume emphysema, just to mention one disease. Now, Patient A makes it known to his family and in fact puts it in writing that if he should ever become hospitalized because of his condition he would not want to be put on any respirator whatsoever. He makes his views known. He faints the following day, and he's brought to the hospital. The very same day Patient B faints, he's brought to the hospital, but he revives. He tells the doctors,

"I do not want to go on the respirator, I refuse to take this treatment." So explain to me any qualitative difference between the two hypothetical situations.

SPINELLA:

Really, the only difference is that one patient is unable to make his wishes known but has done so on paper, not necessarily a "living will" or request, and has left it with his family. Many people properly make this known to their physician, or that kind of statement can be put into a will situation, a real will that comes alive after he is dead. But that wish can very well be carried out, depending on whether or not the family of the patient follows his wish. Incidentally, both of those patients in everyday medical practice would immediately be put on the respirator because anyone who's in that condition no longer requires extraordinary means, it's very ordinary means. The person who has gone on the respirator might be on it for an hour or two hours. Karen Ann Quinlan was brought into the hospital unconscious, ideology unknown, and went right on the respirator; she never came off until the court order. But that's not extraordinary means. Both patients' wishes should be properly followed by the physician. A bill for death with dignity will not help that situation in any way, or make it any clearer. Does that respond or not?

QUESTION:

No, not quite. I would like to make another comment. We had the same problem in our diocese in Vermont. And I personally applaud the position taken by the Bishops in California. I advised my Ordinary that based upon the medical situation in our diocese, the Ordinary should remain aloof from it. We did remain aloof. We were very successful for reasons that you've mentioned, Mr. Spinella, mainly that it's not needed. And we'll let the doctors lead the fight. We stayed out of it as a religious organization. Had we entered the fray we probably would have lost the bill.

SPINELLA:

Well, that may be true in your state, but the opposition in our state started with the Church and it was based on moral principles. We were the ones. I went to the Medical Society meeting, spoke before the meeting and obtained a resolution from that Medical Society opposing the bill, pointing out the legal pitfalls. And I don't think you can remain aloof and expect the doctors to carry the ball entirely. It has the moral dimension and we have to pursue it.

The Church cannot stay out of the question and let the attorneys and the doctors and everybody else take it on. I think for the Church to remain silent is not the position that we should be taking. The concern that I have when we talk about the California bill is that all of a sudden it is before 35 legislatures in our country. The slippery slope has begun very rapidly. I

would like to share with you why I was concerned about this very early in the game. The whole question of death with dignity and legislation came from a Dr. Sackett in Florida. It was about eight years ago that this bill was proposed before the Florida legislature. Dr. Sackett publicly said this: "The intent of this bill with the living will is to clean out the houses, the institutions of the retarded." The reason being that since they cannot make decisions for themselves, a third party will decide what is extraordinary or not extraordinary. He has kind of compounded this by saying that this same bill should be applied to VA hospitals. The point that I'm making is that if you gave me the California bill I could not find anything intrinsically wrong in it, immoral or contrary to Catholic teachings. But I find it very interesting to look at what has flowed from the Supreme Court's decisions on abortion, emphasizing the right to privacy. We went on the question of abortion to protect the life of the mother. That discussion went quickly, within a matter of months, to abortion on demand throughout the country and I would hope that that is not what we are going to be faced with in this discussion. I do know that other people are very, very busy promoting euthanasia.