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"Give me a Few More Minutes!": How Virginia Violates Due Process By Hitting the Snooze Button on a Timely Declaration of Death

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**“GIVE ME A FEW MORE MINUTES!”:
HOW VIRGINIA VIOLATES DUE PROCESS BY HITTING THE
SNOOZE BUTTON ON A TIMELY DECLARATION OF DEATH**

Samantha Lauren Soller*

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Stealing five minutes of extra sleep in the morning is not an unusual way for someone to begin his day. The alarm simply rings again, he gets up, carries on his routine at an accelerated pace, and is no worse for the wear. But sitting back idly while the second hand makes five slow rotations is not always so innocuous. In many instances, minutes—and even fractions thereof—are critical.

One context in which snoozing is less acceptable is organ donation. Organs are sustained by the oxygen and nutrients they receive from circulating blood. When an organ donor dies and his heart stops pumping blood, doctors have mere minutes

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to remove his organs before they are irreparably degraded by lack of blood flow.¹ With that in mind, most states have drafted their death-determination statutes to allow for speedy organ harvesting.² Not Virginia; Virginia hits the snooze button on organ procurement.

Virginia's codification of what constitutes death is very different in one respect from most other states' death statutes.³ Though every state embraces both cardiopulmonary and neurological definitions of death, and every state respects legitimate Do Not Resuscitate (DNR) orders, Virginia has a requirement most states do not have. Virginia commands that before an individual can be declared dead, a physician must determine that artificial cardiopulmonary resuscitation (CPR) would not be successful in resuscitating the individual.⁴ This is the case even when the individual has a valid DNR order.⁵ Virginia's law has a tremendous impact on the effectiveness of harvesting organs and implicates potential donors' fundamental rights to privacy and death.

Part I of this Note describes the mechanics of and laws pertaining to organ transplantation. This sets the stage for understanding why Virginia's law ought to undergo a constitutional analysis. It examines how the meaning of "death" has evolved over time and scrutinizes critical language within these definitions. These details directly impact the rate at which organs can be recovered. Part II focuses on how Virginia's death-determination criteria differ from the way in which the majority of states interpret the Uniform Determination of Death Act. Part III analyzes the constitutional implications of Virginia's law as compared to the requirements endorsed by the rest of the country. Here, the Note examines the right to privacy and how death-determination statutes affect this fundamental right. It also assesses Virginia's potential infringement of the right to death. Both of these subsections examine whether the Commonwealth has compelling enough interests to enact such legislation. Finally, Part IV offers recommendations, ultimately urging Virginia to

¹ See Maxine M. Harrington, *The Thin Flat Line: Redefining Who is Legally Dead in Organ Donation After Cardiac Death*, 86 DENV. U. L. REV. 335, 340 (2009) (citing N.Y. City Health & Hosp. Corp. v. Sulsona, 367 N.Y.S.2d 686, 689 (Sup. Ct. 1975)) (describing how organs that are no longer receiving a supply of blood are not of the best transplantable quality).

² See *infra* Part II.A.

³ See VA. CODE ANN. § 54.1-2972(A)(1) (2010 & Supp. 2011); see also *infra* Part II.

⁴ § 54.1-2972(A)(1) ("A person shall be medically and legally dead if . . . attempts at resuscitation would not, in the opinion of [a] physician, be successful in restoring spontaneous life-sustaining functions.").

⁵ *Id.* at § 54.1-2972(A)-(B). The statute does not contain an exception to the mandate that physicians determine CPR would be unsuccessful in resuscitating the individual for those with DNR orders. See *id.* The only DNR exception is when death is being pronounced by registered nurses and physician assistants, who may pronounce death in very narrow circumstances. *Id.*

reconsider its death-determination law, which likely offends constitutional protections afforded to privacy and death.

I. BACKGROUND

In 1954, Dr. Joseph Murray conducted the first successful organ transplant by implanting a live donor’s kidney into the body of his twin brother.⁶ He performed a similar procedure using a deceased donor eight years later.⁷ By the early 1980s, surgeons had transplanted kidneys, livers, pancreases, intestines, hearts, and lungs removed from cadaveric donors into unrelated recipients.⁸ Today, tens of thousands of lives are saved each year in the United States with this breakthrough medical science.⁹ This would not have occurred, however, without the evolution of the standards governing harvesting and transplantation.

In the early days of organ donation, the only sources of vital organs were deceased individuals.¹⁰ This was due in part to a mandate known as the “dead donor rule,” which makes it unacceptable to harvest vital organs from living humans.¹¹ During these early days, death was defined by common law as the “cessation of life . . . a total stoppage of the circulation of the blood, and a cessation of the animal

⁶ COMM. ON INCREASING RATES OF ORGAN DONATION, BD. ON HEALTH SCIS. POL’Y, ORGAN DONATION: OPPORTUNITIES FOR ACTION 18 (James F. Childress & Catharyn T. Liverman eds., 2006) [hereinafter OPPORTUNITIES FOR ACTION].

⁷ Peter L. Abt et al., *Donation after Cardiac Death in the US: History and Use*, 203 J. AM. COLL. SURGEONS 208, 209 (2006).

⁸ See *History*, UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org/donation/index.php?topic=history> (last visited Mar. 15, 2012) (noting that the first kidney transplant occurred in 1954, the first pancreas and heart transplants in 1968, the first lung transplant in 1983, and the first intestine transplant in 1987).

⁹ As of late October 2011, 523,459 organs had been transplanted in the United States. *Transplants by Donor Type*, ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/> (last visited Mar. 15, 2012) (follow “Data” menu item and choose “View Data Reports”; select “National Data” and choose category “transplant”; follow the “Transplants by Donor Type” hyperlink).

¹⁰ Abt, *supra* note 7, at 208.

¹¹ “The ‘dead-donor rule’ refers to two widely accepted ethical norms that govern practices of organ procurement for transplantation: (1) vital organs should be taken only from dead patients, and (2) living patients should not be killed for or by organ procurement.” *Dead-Donor Rule*, ASCENSION HEALTH, http://www.ascensionhealth.org/index.php?option=com_content&view=article&id=135&itemid=172 (last visited Mar. 15, 2012) (citing Stuart J. Youngner & Robert M. Arnold, *Ethical, Psychological, and Public Policy Implications of Procuring Organs from Non-Heart-Beating Cadaver Donors*, 269 JAMA 2769 (1993)); see also OPPORTUNITIES FOR ACTION, *supra* note 6, at 128 (citing John A. Robertson, *The Dead Donor Rule*, 29 HASTINGS CTR. REP. 6 (1999)) (stating that the dead donor rule requires that “organ donation . . . not cause or hasten death”).

and vital functions . . . such as respiration, pulsation, etc.”¹² When a donor’s heart and lungs stopped operating, physicians could begin the harvesting process without violating the dead donor rule. These donors were referred to as “non-heart-beating donors,”¹³ and the procedure was termed “donation after cardiac death” (DCD).¹⁴ While this was sometimes successful, organs often experienced warm ischemia—deterioration resulting from oxygen deprivation due to lack of circulation—before transplantation.¹⁵ This significantly decreased the likelihood of success for organ transplants.¹⁶ Because the harvesting of vital organs could only occur after the donor’s death, and because death was defined as a cessation of cardiopulmonary function, organs to be donated necessarily experienced some degree of oxygen deprivation, limiting their lifesaving potential.¹⁷ It was not until legal standards underwent a transformation that organ donation became a larger success.¹⁸

A. Defining “Death”

In 1968, just as the medical community began to accept organ transplantation as a viable solution to managing a variety of illnesses, the Ad Hoc Committee of the Harvard Medical School released an opinion on an alternative definition of death

¹² BLACK’S LAW DICTIONARY 488 (4th ed., rev. 1968), *quoted in* Jason L. Goldsmith, Note, *Wanted! Dead and/or Alive: Choosing Among the Not-So-Uniform Statutory Definitions of Death*, 61 U. MIAMI L. REV. 871, 879 n.42 (2007); *see also* Goldsmith, *supra*, at 879 n.42 (describing how this “cardiopulmonary-centric” entry was “subsequently revised by the first ‘post-death-legislation era’ edition to encompass a broader conception: ‘Death. The cessation of life; permanent cessation of all vital functions and signs.’” (quoting BLACK’S LAW DICTIONARY 360 (5th ed. 1979))).

¹³ Jerry Menikoff, *Doubts About Death: The Silence of the Institute of Medicine*, 26 J.L. MED. & ETHICS 157, 157 (1998) (citing Y.W. Cho et al., *Transplantation of Kidneys from Donors Whose Hearts Have Stopped Beating*, 338 NEW ENG. J. MED. 221, 221–25 (1998)) (defining non-heart-beating donors as “individuals who are declared dead not as a result of direct measurements of brain function, but rather as a result of the cessation of heart and respiratory functions”).

¹⁴ Harrington, *supra* note 1, at 337 (explaining that donation after cardiac death involves transplants “using donors whose heart and lung functions have ceased, but who are not yet brain dead”).

¹⁵ INST. OF MED., NON-HEART-BEATING ORGAN TRANSPLANTATION: PRACTICE AND PROTOCOLS XV, at 7–8, 22 (2000), *available at* http://www.nap.edu/catalog.php?record_id=9700 [hereinafter IOM REPORT 2000].

¹⁶ Harrington, *supra* note 1, at 338 (“The closer the donor is to life, the more useful the organs will be to the recipient.”).

¹⁷ IOM REPORT 2000, *supra* note 15, at 7–8 (citing M. Devita et al., *A History of Organ Donation by Patients with Cardiac Death*, 3 KENNEDY INST. OF ETHICS J. 131 (1993) and INST. OF MED., NON-HEART-BEATING ORGAN TRANSPLANTATION: MEDICAL AND ETHICAL ISSUES IN PROCUREMENT (1997)).

¹⁸ *Id.* at 8.

based on neurological criteria.¹⁹ This involves “irreversible coma”—the death of the whole brain²⁰—and would come to bolster the success of organ donation.²¹ Individuals who are brain dead may still maintain circulatory and pulmonary functions by artificial means.²² Because these patients are already considered deceased, surgeons can remove their organs while they are still connected to ventilators and their circulation is intact.²³ This process greatly reduces damage to organ tissues from oxygen deprivation and lack of perfusion pressure.²⁴ Preventing such damage is imperative to the success of later transplantation.²⁵ States looked favorably upon this new definition of death, and by 1980, twenty-four states had codified brain death as a legal criterion for death.²⁶

The same year, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research drafted the Uniform Determination of Death Act (UDDA)²⁷ and recommended its adoption.²⁸ The UDDA states that “[a]n 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.”²⁹ Today, the majority of states have either adopted the UDDA or drafted their own legislation accepting a neurological determination of

¹⁹ Harrington, *supra* note 1, at 341 (citing Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 85, 85 (1968)).

²⁰ *Id.* at 341 n.47; OPPORTUNITIES FOR ACTION, *supra* note 6, at 18.

²¹ Abt, *supra* note 7, at 214.

²² Sarah D. Barber, Note, *The Tell-Tale Heart: Ethical and Legal Implications of In Situ Organ Preservation in the Non-Heart-Beating Cadaver Donor*, 6 HEALTH MATRIX 471, 471 (1996) (describing how DND donor organs “can be maintained in a healthy condition through the use of life support”).

²³ *Id.*

²⁴ Harrington, *supra* note 1, at 340 (stating that recovering organs that were still receiving blood “would avoid the problem of warm ischemia time associated with circulatory death”).

²⁵ See ROGER HERDMAN & JOHN POTTS, NON-HEART-BEATING ORGAN TRANSPLANTATION: MEDICAL AND ETHICAL ISSUES IN PROCUREMENT 24 (1997) (describing the “ideal conditions for organ recovery” as a donor “with the shortest time between absence of circulation and removal of organs”). In general, “recovered organs are stored in a cold organ preservation solution” to prevent deterioration after removal from the body. They can remain in solution for several hours, depending on organ type, before transplantation. *Donor Matching System*, ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/about/transplantation/matchingProcess.asp> (last visited Mar. 15, 2012).

²⁶ Richard M. Zaner, *Introduction to DEATH: BEYOND WHOLE-BRAIN CRITERIA 2* (Richard M. Zaner ed., 1988).

²⁷ UNIF. DETERMINATION OF DEATH ACT § 1, 12A U.L.A. 781 (1980).

²⁸ PRESIDENT’S COMM. FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMED. AND BEHAVIORAL RESEARCH, *DEFINING DEATH: A REPORT ON THE MEDICAL, LEGAL, AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH 2* (1981) [hereinafter *DEFINING DEATH*].

²⁹ UNIF. DETERMINATION OF DEATH ACT § 1.

death.³⁰ Because of this and the success of organ transplants from brain-dead donors, donation after neurological death (DND)³¹ has almost completely replaced DCD over the past several years.³²

B. “Irreversibility”

Despite advances in science, DND, and widespread acceptance of organ donation, the demand for organs far exceeds its supply.³³ The government and medical community have been seeking ways to increase the availability of organs for patients in need.³⁴ One potential strategy is to expand the donor pool to once again include non-heart-beating donors—that is, to use DCD.³⁵ This process, however, has grown complicated with the development of new technologies. In the early days of organ transplantation, when an individual stopped breathing and his heart stopped pumping blood, death was almost certainly inevitable.³⁶ There was only the small chance a patient might “auto-resuscitate” or resume cardiopulmonary function spontaneously.³⁷ It was relatively

³⁰ Goldsmith, *supra* note 12, at 889–90.

³¹ In typical cases, patients with massive brain injury are diagnosed as brain dead while on mechanical ventilation in an intensive care unit (ICU). Physicians perform a series of clinical tests for neurological function. The diagnosis requires that the patient be in a coma and demonstrate no response to battery tests that assess brainstem function. . . . If the findings persist, . . . then the patient is diagnosed as dead. . . . If the patient and family desire to donate organs and if the patient is a suitable candidate, then the patient is taken to the operating room for organ recovery and transplantation, while mechanical ventilation is continued and with the beating heart still perfusing the patient’s organs.

Robert D. Truog, *Brain Death—Too Flawed to Endure, Too Ingrained to Abandon*, 35 J.L. MED. & ETHICS 273, 273 (2007) (citation omitted).

³² Christopher James Doig & David A. Zygun, *(Uncontrolled) Donation after Cardiac Determination of Death: A Note of Caution*, 36 J.L. MED. & ETHICS 760, 760 (2008) (stating that DND has “replaced DCD as the major source of cadaveric organs for transplant in North America”); Suzanne A. Fiddler, *Implementing Donation After Cardiac Death Protocols*, 2 J. HEALTH & LIFE SCI. L. 123, 125 (2008) (stating that “the transplant and organ procurement organization communities essentially abandoned DCD” because of the advantages offered by DND).

³³ OPPORTUNITIES FOR ACTION, *supra* note 6, at 46 (describing the “widening gap between the supply of transplantable organs and the number of patients on the waiting list”).

³⁴ *Id.* at 31–32.

³⁵ *Id.* at 127.

³⁶ See Barber, *supra* note 22, at 486 (discussing how today’s technology “routinely brings people back from ‘death’”).

³⁷ James L. Bernat, *The Boundaries of Organ Donation After Circulatory Death*, 359 NEW ENG. J. MED. 669, 670–71 (2008); K. Hornby et al., *A Systematic Review of Autoresuscitation After Cardiac Arrest*, 38 CRITICAL CARE MED. 1246, 1247 (2010) (citing E.F. Wijdicks & M.N. Diringier, *Electrocardiographic Activity After Terminal Cardiac Arrest in Neurocatastrophes*,

straightforward to determine when an individual had perished.³⁸ Today, machines can resuscitate those who suffer cardiac arrest; the cessation of circulatory and pulmonary functions can be reversed.³⁹ Instead of facing certain death after cardiac arrest, patients today can be revived.⁴⁰ This means that when doctors remove life support systems, the patient may not necessarily die—cardiopulmonary resuscitation may revive the patient.⁴¹ This presents a problem in harvesting organs; if a patient has a chance of revival, a surgeon cannot remove his vital organs without violating the dead donor rule.⁴² The cessation of cardiopulmonary functions must be irreversible before organ procurement may commence.⁴³ Thus, one must wait until there is no chance of resuscitation. The longer circulatory function is absent, the more likely it is irreversible.⁴⁴ Yet this is complicated by the fact that the longer one waits, the less likely the organs harvested will be transplanted successfully.⁴⁵

The Institute of Medicine has determined that five minutes is an appropriate amount of time to be medically certain that cardiopulmonary activity has permanently ceased,⁴⁶ but state statutes vary as to the amount of time required.⁴⁷ A greater

62 NEUROLOGY 673–74 (2004)) (stating that auto-resuscitation “is the phenomenon of the heart being able to restart spontaneously and generate anterograde circulation”).

³⁸ See *id.* at 1246 (“The availability of life-sustaining interventions . . . has obscured our ability to distinguish between the seemingly discrete states of life and death.”).

³⁹ Paul C. Sorum, *Limiting Cardiopulmonary Resuscitation*, 57 ALB. L. REV. 617, 617 (1994) (explaining the use of CPR and how it can restore cardiac function).

⁴⁰ *Id.*

⁴¹ See Bernat, *supra* note 37, at 670–71 (discussing how a heart can be restarted, even after it has been transplanted to another patient).

⁴² See *supra* note 11 and accompanying text.

⁴³ See *supra* note 29 and accompanying text.

⁴⁴ See DEFINING DEATH, *supra* note 28, at 17 (“Once deprived of adequate supplies of oxygen and glucose, brain neurons will irreversibly lose all activity and ability to function.”).

⁴⁵ OPPORTUNITIES FOR ACTION, *supra* note 6, at 131 (explaining that successful transplantation requires minimization of the length of time in which the organ is deprived of oxygen).

⁴⁶ IOM REPORT 2000, *supra* note 15, at 22–24 (explaining the 1997 Report’s determination of a five-minute interval has been accepted by some organ procurement organizations and that further study of the interval’s validity has not been undertaken).

⁴⁷ “U.S. guidelines were either silent or varied significantly with respect to the period of time organ retrieval could begin after heart stoppage. Some allowed organ retrieval immediately after cardiac arrest, while others mandated a waiting period ranging from sixty seconds to five minutes.” Harrington, *supra* note 1, at 348.

Twelve OPO protocols dictate that the declaration of death and beginning of organ removal shall occur a few minutes (60 seconds, 2 minutes, 4 to 5 minutes, etc.) after detection of cardiac arrest. . . . Several protocols declare death and begin procurement immediately ‘after determination of cardiac arrest,’ making no reference to any pause after the final heartbeats.

HERDMAN & POTTS, *supra* note 25, at 40–41.

dispute is taking place over what “irreversible” means.⁴⁸ The Institute of Medicine and transplant community define “irreversible death” to mean that the patient is unable to auto-resuscitate and has a DNR order in place (i.e., he will not be resuscitated artificially).⁴⁹ Virginia does not subscribe to the theory that lacking auto- and artificial resuscitation, an individual is permanently dead; instead it requires a physician to delay a death declaration—and therefore organ harvesting—until he determines that artificial resuscitative attempts would not be effective, despite a DNR order.⁵⁰ Virginia’s technique, and how it differs from those of other states, may be cause for concern.

II. VARIATION AMONG STATES IN DETERMINING DEATH

In a nation with fifty sovereign states, variation in regulatory matters is difficult to avoid. Often, legislators do not try to evade it; Americans accept that different states have different laws. Virginia’s death-determination distinctions alone do not raise issues. The determination law is problematic, however, if it infringes on the constitutional rights of those it affects. A closer examination of states’ varying codifications of death determinations may bring some of the potential implications of Virginia’s law to light.

A. Uniform Determination of Death Act Majority Process

The uncertainty as to when death occurs—or, more precisely, when legal death ought to be said to have occurred—is perhaps the most contentious issue in organ donation. Despite the fact that most American jurisdictions have adopted the Uniform Determination of Death Act in some form,⁵¹ the procedures for determining death are far from uniform.⁵² Legal scholars, medical professionals, and the transplant community debate an event that laypeople for centuries had no difficulty establishing—when one’s life is extinguished.⁵³ One of the primary barriers to agreement is the determination of what constitutes irreversibility, a term the UDDA does not define, but includes in its definition of death.⁵⁴ The Institute of Medicine (IOM), in its 2000 report, has offered three possible interpretations for “irreversible” in this context:

⁴⁸ Harrington, *supra* note 1, at 352 (noting that “[n]either the UDDA nor its state counterparts define the term irreversible”).

⁴⁹ *Id.* at 354.

⁵⁰ See VA. CODE ANN. § 54.1-2972(A)(1) (2010 & Supp. 2011).

⁵¹ Goldsmith, *supra* note 12, at 890.

⁵² See *id.* at 917–18.

⁵³ See, e.g., Bernat, *supra* note 37, at 671 (discussing a new medical study recommending a 75-second lack of cardiac electric activity—or “asystole”—the IOM recommendation of a five-minute interval, the two-minute interval used by some protocols, and the need to determine intervals by “scientific and public policy considerations”).

⁵⁴ Harrington, *supra* note 1, at 354.

(1) [T]he patient’s circulation will not spontaneously resume absent outside intervention (autoresuscitation); (2) the patient’s circulation will not be reversed because the patient or family has chosen to withdraw life support and to refuse further resuscitative efforts; or (3) the patient’s circulation can not be reversed, even with cardiopulmonary resuscitation (CPR) or other technical means.⁵⁵

In its adoption of two to five minutes as the acceptable waiting period before harvesting organs, the IOM has embraced the first two constructions enumerated above.⁵⁶ It is highly improbable that a patient will auto-resuscitate after five minutes have elapsed,⁵⁷ and if he has effected a DNR order, he will not be revived by artificial means.⁵⁸ Essentially, this patient has no chance of recovery after five minutes of cardiac arrest, assuming the physicians respect his DNR order. Therefore, no ethical breach is associated with organ procurement after five minutes of cardiac arrest when a DNR order exists.⁵⁹

Recall that the third construction requires a physician to wait until CPR would no longer be effective to declare time of death, whether or not the patient has entered a DNR order.⁶⁰ If harvesting occurs after only five minutes in a jurisdiction that adopts exclusively this third construction, the dead donor rule is necessarily violated because organ procurement began while there was still an opportunity for resuscitation. Individuals may be successfully artificially resuscitated after five minutes of absent cardiopulmonary activity.⁶¹ This may be why the IOM appears to reject the third construction of “irreversibility,” which necessarily inhibits successful organ donation by increasing the time organs are allowed to deteriorate without blood supply.⁶²

⁵⁵ *Id.* (citing IOM REPORT 2000, *supra* note 15, at 24).

⁵⁶ Harrington, *supra* note 1, at 354.

⁵⁷ Bernat, *supra* note 37, at 671 (recounting that “autoresuscitation has never been reported after 65 seconds of asystole,” and that the longest a human auto-resuscitated after cardiac arrest was one minute).

⁵⁸ Generally, cardiopulmonary resuscitation is a combination of rescue breathing and chest compressions delivered to victims thought to be in cardiac arrest. When cardiac arrest occurs, the heart stops pumping blood. CPR can support a small amount of blood flow to the heart and brain to “buy time” until normal heart function is restored.

Cardiopulmonary Resuscitation, AMERICAN HEART ASSOCIATION, <http://www.americanheart.org/presenter.jhtml?identifier=4479> (last visited Mar. 15, 2012) (accessed by searching for the URL in the Internet Archive).

⁵⁹ If a physician begins CPR on a non-DNR patient who began cardiac arrest less than five minutes prior, however, there is a chance he will be revived. Harrington, *supra* note 1, at 354 (describing how “many patients *can be* successfully resuscitated after this short an interval”).

⁶⁰ *Id.* at 354.

⁶¹ See *id.* at 358.

⁶² *Id.* at 354.

Most states, consistent with the IOM, adopt the first two constructions of the term “irreversible”; therefore, they have statutes that both facilitate organ donation procedures and ensure that organ donors will not be operated on if they have a chance of revival.⁶³ In addition, these states respect donors’ wishes not to be resuscitated by beginning the harvesting process before the point at which artificial resuscitation would be ineffective.

B. Virginia’s Process, and Another Outlier

Similar to all other states, Virginia permits a declaration of death upon either whole brain or cardiac death.⁶⁴ For cardiac death, however, a physician must determine that “there is the absence of spontaneous respiratory and spontaneous cardiac functions and . . . attempts at resuscitation would not, in the opinion of such physician, be successful in restoring spontaneous life-sustaining functions.”⁶⁵ While most states respect a patient’s last wish to refuse artificial life-sustaining measures, Virginia appears to adopt the Institute of Medicine’s third construction of “irreversible.”⁶⁶ This suggests that a patient who wishes to donate his organs and who has entered a DNR order cannot be declared “dead” for purposes of organ donation until his doctor determines that artificial resuscitation attempts would not be successful. The definition thus disregards a patient’s DNR order by incorporating artificial resuscitation into the calculus for determining when death occurs, delaying the call of death for five or more minutes.⁶⁷ This flies in the face of logic and self-determination as well as the Supreme Court’s recognition of an individual’s right to die by “refusing unwanted medical treatment.”⁶⁸

Virginia is not alone, however, in its treatment of this issue. Oklahoma’s death statute also has a unique interpretation of the term “irreversible.” Oklahoma requires that “all reasonable attempts to restore spontaneous circulatory or respiratory functions

⁶³ *See id.* (describing how only “a few states favor a strict construction of irreversible in their death statutes”).

⁶⁴ VA. CODE ANN. § 54.1-2972 (A)(1)–(2) (2010 & Supp. 2011).

⁶⁵ *Id.* at § 54.1-2972(A)(1).

⁶⁶ *Id.* (requiring that physicians opine that attempts at resuscitation would not be “successful in restoring spontaneous life-sustaining functions before declaring death”); *see also supra* note 60 and accompanying text.

⁶⁷ Debate exists regarding the point at which one could firmly establish that artificial resuscitation would no longer revive a patient in asystole. Assuming an individual’s brain must have ceased functioning for him to be declared dead, this point may be ten or fifteen minutes after asystole. James M. DuBois, *Is Organ Procurement Causing the Death of Patients?*, 18 ISSUES L. & MED. 21, 34 (2002) (citing Joanne Lynn, *Are the Patients Who Become Organ Donors Under the Pittsburgh Protocol for “Non-Heart-Beating Donors” Really Dead?*, 3 KENNEDY INST. ETHICS J. 167, 170 (1993)).

⁶⁸ *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990) (inferring this right from the Fourteenth Amendment based on previous cases).

shall first be made, prior to [a death] declaration.”⁶⁹ This is even stricter than Virginia’s statute, which only requires a determination that CPR would not be effective.⁷⁰ In Oklahoma, the statute on its face requires reasonable attempts at CPR.⁷¹

Though not the sole instance of departure from the norm, Virginia’s death statute is still an outlier ripe for constitutional analysis. The critical distinguishing feature of the Commonwealth’s law is the inclusion of CPR in the death determination. Admittedly, in most instances, this consideration is meaningless. For example, if a non-donor suffers cardiac arrest while in the hospital and has an effective and unambiguous DNR order, physicians will likely refrain from performing CPR and allow the patient to die peacefully.⁷² As soon as it becomes clear that this patient’s heart has actually stopped and the lack of beat is not from an irregular rhythm, death is certain.⁷³ It is of no consequence that the patient’s brain may still be flickering for another ten or fifteen minutes; the patient has expressed his wish to refuse artificial life-sustaining measures.⁷⁴ In this respect, Virginia’s law requiring doctors to wait to call time of death until after they determine that no efforts at CPR would be effective is of little value. The patient’s family will accept the cessation of the heartbeat as the end of their loved one’s life, and it is inconsequential that the doctor has to report the death minutes after auto-resuscitation would have been impossible.

Virginia’s law does become an issue, however, when time of death is pivotal, as with regard to organ donation.⁷⁵ Organ donors have expressly communicated their desire not only to donate their organs, but in many instances to avoid being subjected to artificial resuscitative efforts. Because such donors have stated that they do not wish to undergo CPR, the effects of CPR should not be criteria for determining whether donors are “dead” for purposes of organ procurement.⁷⁶ This implicates a

⁶⁹ OKLA. STAT. ANN. tit. 63 § 3122(2) (West 2011).

⁷⁰ VA. CODE ANN. § 54.1-2972(A)(1) (2010 & Supp. 2011).

⁷¹ OKLA. STAT. ANN. tit. 63 § 3122(2).

⁷² See VA. CODE ANN. § 54.1-2987.1(B) (providing that “[i]n no case shall any person other than the patient have authority to revoke a Durable Do Not Resuscitate Order executed upon the request of and with the consent of the patient himself”).

⁷³ The individual has a DNR order in place; revival efforts will not be attempted.

⁷⁴ See generally Bernat, *supra* note 37.

⁷⁵ *Id.* at 671 (stating that “the sooner death can be declared after asystole, the less damage from warm ischemia will occur in the organs”); HERDMAN & POTTS, *supra* note 25, at 26 (listing “a prompt determination of death and organ retrieval” as a “favorable condition[]” of a donor).

⁷⁶ There are no statistics available to quantify empirically the harmful effect of Virginia’s law on organ donation. No figure exists that represents the number of transplants foregone due to deterioration of post-maturely harvested organs; similarly, there is no statistic showing what percentage of potential organ donors on life support actually become donors of viable, transplantable organs in Virginia as compared with other states. This being said, from 2006 to 2010, Virginia had 673 deceased donors from whom organs were recovered. *Donors Recovered in the U.S. for Virginia*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/latestData/viewDataReports.asp> (last visited Mar. 15, 2012).

variety of constitutional issues, including privacy, death, and an individual's authority to determine the effects on his own body.⁷⁷ Americans would find foreign the notion that unwelcome invasions of their bodies are permissible. In the same vein, society has faith that medical professionals will respect DNR orders, written conveyances of the will of a patient.⁷⁸ "Because controlled donors choose to be withdrawn from life support and it would be unethical, if not legally wrong, to resuscitate these individuals, it is acceptable to construe irreversibility to mean that we *will not* reverse, not that we *cannot* reverse, circulatory functions."⁷⁹ This ethical dilemma is the subject of this Note's due process analysis.

Virginia is part of the Organ Procurement and Transplantation Network's Region 11, which also includes North Carolina, South Carolina, Kentucky, and Tennessee. *OPTN Regions/Members*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/members/regions.asp> (last visited Mar. 15, 2012). Region 11, in this same time period, saw 4,685 deceased donors from whom organs were recovered. *OPTN Donors Recovered in the U.S. for Region 11*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/latestData/rptData.asp> (last visited Mar. 15, 2012). Virginia's contribution represents just over fourteen percent. Compare this to the states' respective populations: in 2010, the population of Virginia was 8,001,024. *Virginia Quickfacts*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/51000.html> (last visited Mar. 15, 2012). The same year, the population of Region 11 was 32,847,343. See *Kentucky QuickFacts*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/21000.html> (last visited Mar. 15, 2012); *North Carolina QuickFacts*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/37000.html> (last visited Mar. 15, 2012); *South Carolina QuickFacts*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/45000.html> (last visited Mar. 15, 2012); *Tennessee QuickFacts*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/47000.html> (last visited Mar. 15, 2012); *Virginia Quickfacts*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/51000.html> (last visited Mar. 15, 2012). Virginia comprises almost one quarter of the population of Region 11, but only fourteen percent of deceased donors from whom organs were harvested. Though there are other variables that may explain these percentages (such as higher or lower donor proportions within populations), these statistics suggest that Virginia falls behind her peers in producing recoverable organs.

⁷⁷ See *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914), *rev'd on other grounds*, 143 N.E.2d 3 (1957) (stating that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body").

⁷⁸ The Patient Self-Determination Act of 1990 requires that hospitals provide patients with written materials related to advance directives and patient wishes. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388-115 (West 1992 & Supp. 1995) (codified at 42 U.S.C.A. § 1395cc(f)(A)). These materials must explain to patients their decision-making rights. *Id.* at § 1395cc(A)(i); see also CODE OF MED. ETHICS OP. 2.20, AM. MED. ASS'N, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.shtml> (stating that physicians must "respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity"); CODE OF MED. ETHICS OP. 2.22, AM. MED. ASS'N, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion222.shtml> (stating that "advance directives stating patients' refusals of CPR should be honored").

⁷⁹ Harrington, *supra* note 1, at 356-57.

III. DUE PROCESS

Fundamental rights are those that are afforded special protection under the Due Process Clause of the Fourteenth Amendment.⁸⁰ Rights are granted this fundamental status when they are explicitly or implicitly identified in the Constitution.⁸¹ The violation of such rights creates a constitutional issue of substantive due process.⁸²

Curtailing fundamental rights is permissible, but it requires a strict scrutiny review of the law allegedly infringing on that right.⁸³ In *United States v. Carolene Products Co.*,⁸⁴ the Court stated that laws that implicate constitutional protections should not be presumed to be constitutional.⁸⁵ A “‘more searching judicial inquiry’ is appropriate when . . . a law . . . interferes with individual rights.”⁸⁶ To pass this more intense review, a law must satisfy three requirements. First, the law must be justified by a compelling state interest.⁸⁷ “The decisions of [the Supreme] Court have consistently held that only a compelling state interest in the regulation of a subject . . . can justify limiting . . . freedoms.”⁸⁸ Second, it must be narrowly tailored.⁸⁹ And third,

⁸⁰ ERWIN CHEMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 792 (3d ed. 2006) (“The Supreme Court has held that some liberties are so important that they are deemed to be ‘fundamental rights’ Almost all of these rights have been protected by the Court under the due process clauses of the Fifth and Fourteenth Amendment.”).

⁸¹ *Id.*

⁸² *Id.* at 546 (“*Substantive due process* . . . asks whether the government has an adequate reason for taking away a person’s life, liberty, or property.”).

⁸³ *Id.* at 539 (“If it is an area where there is reason for great suspicion of the government or a fundamental right is at stake, the government will be required, by the level of scrutiny, to meet a heavy burden.”).

⁸⁴ 304 U.S. 144 (1938).

⁸⁵ *Id.* at 152 n.4 (“There may be narrower scope for operation of the presumption of constitutionality when legislation appears on its face to be within a specific prohibition of the Constitution.”).

⁸⁶ CHEMERINSKY, *supra* note 80, at 540 (quoting *Carolene Prods.*, 304 U.S. at 152 n.4).

⁸⁷ *See, e.g.*, *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995) (holding that racial classifications, which are an infringement of the fundamental right of equal protection, are only constitutional if they are “narrowly tailored measures that further compelling governmental interests”); *Sherbert v. Verner*, 374 U.S. 398, 406 (1963) (holding that an unemployment compensation statute was unconstitutional because there was no compelling state interest that justified “the substantial infringement of [the] appellant’s First Amendment rights”).

⁸⁸ *NAACP v. Button*, 371 U.S. 415, 438 (1963).

⁸⁹ *See, e.g.*, *Wygant v. Jackson Bd. of Educ.*, 476 U.S. 267, 280 (1986) (“Under strict scrutiny the means chosen to accomplish the State’s asserted purpose must be specifically and narrowly framed to accomplish that purpose.”); *Fullilove v. Klutznick*, 448 U.S. 448, 480 (1980) (recognizing “the need for careful judicial evaluation to assure that” any infringement of equal protection, a fundamental right, “is narrowly tailored to the achievement” of its goals).

the law must be the least restrictive means to meet the state's justified ends.⁹⁰ Only when the government has met the burden⁹¹ of demonstrating these criteria can the right-infringing legislation be deemed constitutional.⁹²

Privacy and death are two rights familiar to the Court and the American people. They have undergone the fundamental rights analysis in different contexts, and can be applied to the present issue of Virginia's declaration of death statute.

A. Right to Privacy

1. Privacy as a Fundamental Right

Though the Constitution does not expressly mention the right to privacy, the Supreme Court has repeatedly held that it is constitutionally protected.⁹³ In *Griswold v. Connecticut*,⁹⁴ the Court affirmed the privacy right of married couples to use contraceptive products.⁹⁵ *Eisenstadt v. Baird*⁹⁶ also endorsed the right to privacy as to contraception.⁹⁷ The Court in *Lawrence v. Texas*⁹⁸ ruled that intimate same-sex relations are also protected by the right to privacy.⁹⁹ *Loving v. Virginia*¹⁰⁰ established

⁹⁰ See, e.g., *Thomas v. Review Bd. of Ind. Emp. Sec. Div.*, 450 U.S. 707, 718 (1981) (“The state may justify an inroad on religious liberty, ‘a fundamental right,’ by showing that it is the least restrictive means of achieving some compelling state interest.”).

⁹¹ See, e.g., *Burson v. Freeman*, 504 U.S. 191, 217 (1992) (Stevens, J., dissenting) (noting that the State “unquestionably bears the heavy burden of demonstrating that its” deprivation of specific fundamental rights “is necessary and narrowly tailored to serve a compelling state interest”).

⁹² See *supra* notes 87, 89–90.

⁹³ See, e.g., *Lawrence v. Texas*, 539 U.S. 558 (2003); *Roe v. Wade*, 410 U.S. 113 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Loving v. Virginia*, 388 U.S. 1 (1967); *Griswold v. Connecticut*, 381 U.S. 479 (1965); see also *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

⁹⁴ 381 U.S. 479.

⁹⁵ See *id.* at 486 (Goldberg, J., concurring) (reaffirming the Court’s holding that Connecticut’s ban on the use of contraceptives “unconstitutionally intrudes upon the right to marital privacy”).

⁹⁶ 405 U.S. 438.

⁹⁷ *Id.* at 453 (“If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”).

⁹⁸ 539 U.S. 558.

⁹⁹ *Id.* (holding that the “Texas statute making it a crime for two persons of the same sex to engage in certain intimate sexual conduct was unconstitutional, as applied to adult males who had engaged in a consensual act of sodomy in the privacy of their home”).

¹⁰⁰ 388 U.S. 1 (1967); see also *Zablocki v. Redhail*, 434 U.S. 374, 384 (1978) (“The right to marry is part of the fundamental ‘right of privacy’ implicit in the Fourteenth Amendment’s Due Process Clause.”).

the right to privacy in selecting a spouse.¹⁰¹ Most famously, the Supreme Court in *Roe v. Wade*¹⁰² grounded the decision of whether to terminate a pregnancy in privacy rights.¹⁰³ Most on point as to the present issue, *Cruzan v. Director of Missouri Department of Health*¹⁰⁴ upheld the right to privacy in refusing medical treatment.¹⁰⁵

The Bill of Rights creates auxiliary privacy rights in addition to those rights specifically granted.¹⁰⁶ For example, even though the First Amendment does not mention prerogatives like parental choice with regard to their children’s education or study of specific foreign languages, the Supreme Court has held that it includes both.¹⁰⁷ These “penumbras” of Bill of Rights privacy guarantees generate broad “zones of privacy” for American citizens.¹⁰⁸ The right to privacy in deciding what to do with one’s body, as in timely organ donation, surely sits in the shadows of the expressed rights protecting citizens from oppressive government intervention. As Justice Goldberg wrote in his *Griswold* concurrence: “[T]he concept of liberty protects those personal rights that are fundamental, and is not confined to the specific terms of the Bill of Rights.”¹⁰⁹

In addition to these more specific aspects of privacy, the Supreme Court has declared that there is a general right to privacy found in both the Ninth¹¹⁰ and Fourteenth¹¹¹ Amendments to the Constitution.¹¹² The Ninth Amendment guards

¹⁰¹ *Id.* at 12 (offering that the “Fourteenth Amendment requires that the freedom of choice to marry not be restricted by invidious racial discrimination”).

¹⁰² 410 U.S. 113 (1973).

¹⁰³ *Id.* at 153 (declaring that the constitutional “right of privacy . . . is broad enough to encompass a woman’s decision whether or not to terminate her pregnancy”).

¹⁰⁴ 497 U.S. 261 (1990).

¹⁰⁵ *Id.* at 278 (inferring “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment”).

¹⁰⁶ *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (citing cases that “suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance”).

¹⁰⁷ *Id.* at 482 (discussing the rights upheld in *Pierce v. Soc’y of Sisters*, 268 U.S. 510 (1925) and *Meyer v. Nebraska*, 262 U.S. 390 (1923), which are “the right to educate one’s children as one chooses” and “the right to study the German language in a private school”).

¹⁰⁸ *Id.* at 484.

¹⁰⁹ *Id.* at 486 (Goldberg, J., concurring).

¹¹⁰ “The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.” U.S. CONST. amend. IX.

¹¹¹ No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. amend. XIV, § 1.

¹¹² *Griswold*, 381 U.S. at 492 (Goldberg, J., concurring) (describing how “the Ninth Amendment shows a belief of the Constitution’s authors that fundamental rights exist that are not expressly enumerated”); *id.* at 493 (describing how the “Fourteenth Amendment prohibits the States . . . from abridging fundamental personal liberties”).

against the possibility that an express mention of certain rights would lead to the belief that all others are excluded.¹¹³ In his concurrence in *Griswold*, Justice Goldberg stated: “The language and history of the Ninth Amendment reveal that the Framers of the Constitution believed that there are additional fundamental rights, protected from governmental infringement, which exist alongside those fundamental rights specifically mentioned in the first eight constitutional amendments.”¹¹⁴ Justice Goldberg further explained that James Madison, the author of the amendment, was afraid of listing specific rights, thereby denying rights that went unmentioned.¹¹⁵ Madison was not the only Founder concerned with protecting the unenumerated rights of Americans. Alexander Hamilton believed the Bill of Rights’ enumeration of liberties would be superfluous, since the government did not possess powers that were not explicitly delegated to it.¹¹⁶ The Ninth Amendment was included, just in case, to ensure the preservation of unwritten liberties.¹¹⁷ Thus, though privacy is not mentioned by name, it is not without protection.

The Fourteenth Amendment decrees that no State shall “deprive any person of life, liberty, or property without due process of law.”¹¹⁸ The nation’s Founders were clearly concerned with the preservation of liberties not explicitly set forth in the Constitution.¹¹⁹ In *Griswold*, Justice Goldberg showed that the Court views the Fourteenth Amendment as guaranteeing a broad privacy right.¹²⁰ Justice Harlan, in his concurrence in the same case, expressed that the Fourteenth Amendment is “on its own bottom,” meaning that it in itself protects individuals from encroachments on privacy.¹²¹ Other cases have also determined that privacy is an elemental component of liberty. The *Lawrence* Court ruled that a law regulating private conduct was unconstitutional.¹²² The opinion stated that the “[p]etitioners’ right to liberty under the Due Process Clause g[ave] them the full right to engage in private conduct without government intervention.”¹²³ Similarly, as the Court stated in *Planned Parenthood v. Casey*,¹²⁴ “It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter.”¹²⁵ The right to privacy, therefore, has much broad support in Supreme Court history.

¹¹³ See U.S. CONST. amend. IX.

¹¹⁴ *Griswold*, 381 U.S. at 488; see also U.S. CONST. amend. IX.

¹¹⁵ *Griswold*, 381 U.S. at 488–89 (describing how “the specific mention of certain rights would be interpreted as a denial that others were protected”).

¹¹⁶ THE FEDERALIST No. 84, at 420 (Alexander Hamilton) (Terence Ball ed., 2003).

¹¹⁷ *Griswold*, 381 U.S. at 488–89.

¹¹⁸ U.S. CONST. amend. XIV.

¹¹⁹ *Griswold*, 381 U.S. at 488–89.

¹²⁰ See *id.* at 488, 493.

¹²¹ *Id.* at 500 (Harlan, J., concurring).

¹²² *Lawrence v. Texas*, 539 U.S. 558 (2003).

¹²³ *Id.* at 560.

¹²⁴ 505 U.S. 833 (1992).

¹²⁵ *Id.* at 847.

2. Privacy in Organ Donation

Though privacy is generally deemed a right of fundamental importance,¹²⁶ not every aspect of privacy may qualify for this elevated status.¹²⁷ At issue in this particular case is an individual’s wish to be removed from artificial life-sustaining technologies with the supplementary, yet independent, purpose of donating his organs in mind. At the critical juncture, this individual is not brain dead, but he has suffered cardiac arrest and is kept alive by a mechanical ventilator. Though all or part of his brain is functioning, it will die approximately ten to fifteen minutes after life support systems are removed.¹²⁸ The potential donor has entered a DNR order and indicated he would like to give his organs as gifts.¹²⁹

Individuals in such situations assert the broad right to self-definition. Not only do they seek to define their lives, they also aim to define their deaths. They have entered DNR orders and do not wish to be sustained by artificial means. The Supreme Court in *Lawrence* upheld as fundamental the right to self-definition.¹³⁰ The Court has further recognized this as a basic privacy right.¹³¹ The *Cruzan* Court made a similar ruling, holding that “the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death.”¹³² Bodily integrity is also of great importance.¹³³

In Virginia, this potential organ donor is subject to the statutory codification governing death determination.¹³⁴ His organs cannot be harvested until he has passed

¹²⁶ See *supra* Part III.A.1.

¹²⁷ See, e.g., *Roe v. Wade*, 410 U.S. 113, 163 (holding that women do not have the right to terminate pregnancy after the first trimester, and that “after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health”).

¹²⁸ DEFINING DEATH, *supra* note 28, at 16–17 (“If deprived of blood flow for at least 10–15 minutes, the brain, including the brainstem, will completely cease functioning.”).

¹²⁹ Nearly every American jurisdiction has a statutory provision allowing individuals to predetermine their end-of-life treatment through advance directives and living wills. Adam A. Milani, *Better Off Dead Than Disabled?: Should Courts Recognize a “Wrongful Living” Cause of Action When Doctors Fail to Honor Patients’ Advance Directives?*, 54 WASH. & LEE L. REV. 149, 159 (1997); see UNIF. ANATOMICAL GIFT ACT § 2(b) (1987), 8A U.L.A. 1 (2003) (requiring that anatomical gifts be made by written documents); see also John Donohue, *“Wrongful Living”: Recovery for a Physician’s Infringement on an Individual’s Right to Die*, 14 J. CONTEMP. HEALTH L. & POL’Y 391, 397 n.27 (listing the statutes for the forty-four states that codify living will laws).

¹³⁰ *Lawrence v. Texas*, 539 U.S. 558, 562 (2003) (stating that “[l]iberty presumes an autonomy of self”).

¹³¹ See *supra* Part III.A.1.

¹³² *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 273 (1990).

¹³³ *Id.* at 269 (“[N]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person.” (quoting *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891))).

¹³⁴ See VA. CODE ANN. § 54.1-2972(A)(1) (2010 & Supp. 2011).

the point, temporally, when artificial resuscitation would be ineffective.¹³⁵ This is later than the time at which auto-resuscitation would no longer be possible.¹³⁶ This state-imposed delay for declaring the intended donor deceased disturbs his right to self-definition, bodily control, and privacy.

The degree to which a right must be protected depends on whether it is deeply rooted in history and tradition and/or implicit in ordered liberty.¹³⁷ The Fourteenth Amendment actively protects rights “so rooted in the traditions and conscience of our people as to be ranked as fundamental.”¹³⁸ The first question is thus whether the liberty invoked here “is of such a character that it cannot be denied without violating those ‘fundamental principles of liberty and justice which lie at the base of all our civil and political institutions.’”¹³⁹ The exact intentions of an individual seeking a timely death declaration do not have a firm footing in historical convention, but this should not affect adversely a potential donor because his predicament is a fairly modern one.¹⁴⁰ Similar liberties have been deemed fundamental in the past.¹⁴¹ Most significant is the right to refuse medical treatment, established as a fundamental right in *Cruzan*.¹⁴² The present analysis parallels that of refusing life-saving medical treatment because the situation involves a determination of death dependent on whether life-saving treatment would be successful. Thus, a history of eschewing resuscitative measures at the patient’s request is apparent.

Certainly, organ donors intend for their organs to be transplanted successfully into needy recipients, or at least that best efforts be made.¹⁴³ Short of disrupting their own comfort, they seek to ensure that the donation procedure progresses as safely and

¹³⁵ *Id.*

¹³⁶ *See supra* note 67.

¹³⁷ *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997) (“We begin, as we do in all due process cases, by examining our Nation’s history, legal traditions, and practices.”); *see also* Bret D. Asbery, *Law as Palimpsest: Conceptualizing Contingency in Judicial Opinions*, 61 ALA. L. REV. 121, 139 (2009) (citing *Bowers v. Hardwick*, 478 U.S. 186, 191–92 (1986)).

¹³⁸ *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (citations omitted).

¹³⁹ *Powell v. Alabama*, 287 U.S. 45, 67 (1932) (quoting *Hebert v. Louisiana*, 272 U.S. 312, 316 (1926)).

¹⁴⁰ Robert Steinbrook, *Organ Donation after Cardiac Death*, 357 NEW ENG. J. MED. 209, 212 (2007), available at <http://www.nejm.org/doi/full/10.1056/NEJMp078066> (describing how the Joint Commission on Accreditation of Healthcare Organization’s “first accreditation standard for donation after cardiac death” did not arise until 2007).

¹⁴¹ *See, e.g.*, *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990) (establishing the right to remove life-sustaining treatment); *Brotherton v. Cleveland*, 923 F.2d 477 (6th Cir. 1991) (granting a woman a possessory interest—but not full property rights—in the body of her deceased husband when the state made organ donation decisions without her consent).

¹⁴² *Cruzan*, 497 U.S. at 261.

¹⁴³ Organ donation in the United States is voluntary. *See* UNIF. ANATOMICAL GIFT ACT § 2(a) (1987), 8A U.L.A. 27 (2003) (noting that individuals may refuse to make anatomical gifts); *Uniform Anatomical Gift Act Enactment Status Map*, UNIFORM LAW COMMISSION, [http://www.nccusl.org/Act.aspx?title=Anatomical Gift Act](http://www.nccusl.org/Act.aspx?title=Anatomical%20Gift%20Act) (2006) (last visited Mar. 15, 2012) (listing Virginia as a state that has enacted the Act).

efficiently as possible. This expectation is apparent from a donor’s voluntary decision to be classified as an organ donor.¹⁴⁴ Though it is safe to assume that most soon-to-be donors anticipate a reasonable amount of precaution to ensure permanent death, it is unreasonable to argue that they anticipate CPR—something they have expressly declined—will constitute part of the death calculus. An approach such as Virginia’s, which interferes with organ donation in this manner, is contrary to the American tradition of respecting the dying individual’s final requests.¹⁴⁵

Additionally, an intended donor’s right to a death determination independent of resuscitative efforts is fundamental to the concept of liberty itself. Individuals who elect to forego resuscitative attempts and donate organs should not have their deaths based on when such attempts would be unsuccessful. Although no one can have full property rights in organs,¹⁴⁶ those on their deathbed are entitled to dictate what they wish to be done with their bodies.¹⁴⁷ Additionally, next of kin of the deceased have at least a possessory interest in the corpse, which should enable them to ensure that donation occurs as the deceased desired.¹⁴⁸ In a free society where Good Samaritans are willing to subject their bodies to post-mortem mutilation, these Samaritans’ expectations should be met. The State should not deceive them into thinking a hospital will make its best efforts to conduct a successful, safe transplantation when laws prohibit this. If these individuals knew the odds were not as high as possible,¹⁴⁹ they might choose to rethink the post-mortem mutilation. This is especially true for individuals who elect to be organ donors in a majority rule-conforming state and face a declaration of death in a state like Virginia.

¹⁴⁴ See *supra* note 143.

¹⁴⁵ See Frances H. Foster, *Individualized Justice in Disputes Over Dead Bodies*, 61 VAND. L. REV. 1351, 1376–79 (2008) (listing many “instruments to promote a decedent’s control over her remains”).

¹⁴⁶ See *Moore v. Regents of Univ. of Cal.*, 793 P.2d 479, 488 (Cal. 1990) (holding that an individual does not necessarily have property rights to his cells after their removal from his body).

¹⁴⁷ See Foster, *supra* note 145, at 1376–78.

¹⁴⁸ *Brotherton v. Cleveland*, 923 F.2d 477, 480 (6th Cir. 1991) (stating that “[a] majority of the courts confronted with the issue of whether a property interest can exist in a dead body have found that a property right of some kind does exist and often refer to it as a ‘quasi-property right,’” and noting that this includes preparation for burial); *Spiegel v. Evergreen Cemetery Co.*, 186 A. 585, 586 (N.J. 1936) (“[I]t is now the prevailing rule, in England as well as in this country, that the right to bury the dead and preserve the remains is a quasi right in property.”). But see *State v. Powell*, 497 So.2d 1188 (Fla. 1986), in which family members did not want the decedent’s corneas removed, but the coroner removed them anyway. *Id.* at 1188. Family members asserted a fundamental right to control the disposition of the deceased’s body, but the court held that privacy provisions do not protect such an intrusion into one’s private life. *Id.* at 1193.

¹⁴⁹ See Harrington, *supra* note 1, at 338 (“The speed with which a diagnosis of death is made in the DCD context is done solely to facilitate organ procurement. The closer the donor is to life, the more useful the organs will be to the recipient.”).

A solid case is thus presented for designating a timely death determination a fundamental right. Virginia would argue that both prongs—history/tradition and implicit in ordered liberty—must be satisfied,¹⁵⁰ and it appears that the organ donor would prevail on this point. To enact a regulation that infringes upon a fundamental right such as this, a State must demonstrate a compelling interest in the effect of the legislation.

3. Compelling Interest

Generally, privacy is a fundamental right.¹⁵¹ This does not mean that all conceptions of privacy are constitutionally protected.¹⁵² In some instances, the State has a sufficient interest in regulating an activity, such that it may deprive an individual of his or her right to privacy.¹⁵³ A thorough due process analysis weighs a state's compelling interest against the right in question to determine whether the government can legally infringe upon privacy in a given domain.

Assuming the privacy right to die peacefully without artificial attempts at resuscitation and to donate organs is a fundamental right, a state must show a compelling interest in compromising this right. "Once a court determines that a privacy right exists, the court next must determine whether '[abrogation of the right] serves a compelling state interest' and whether '[abrogation] can be made in the least intrusive manner.'"¹⁵⁴ The question is whether an individual's right to privacy and self-definition in organ donation trumps the State's interest in protecting his health and adhering to other laws. Very broadly, Virginia's interests include "preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession," though the first is most important.¹⁵⁵

It appears that the Commonwealth is concerned that vital organs may be harvested before a donor is actually dead, in violation of the dead donor rule.¹⁵⁶ The Commonwealth may also deem it imperative to ensure that no further attempts at resuscitation would succeed before engaging in a surgery that would kill an individual not already dead. This is the primary conflict to be resolved in this analysis. The potential donor seeks a death determination that reflects his expressed wishes to refuse medical treatment; the State aims to protect his life and those of others in his

¹⁵⁰ See *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997).

¹⁵¹ See *supra* Part III.A.1.

¹⁵² See *Glucksberg*, 521 U.S. at 727 (stating that merely because "many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected"); *supra* Part III.A.2.

¹⁵³ *Bates v. City of Little Rock*, 361 U.S. 516, 524 (stating, "[w]here there is a significant encroachment upon personal liberty, the State may prevail only upon showing a subordinating interest which is compelling").

¹⁵⁴ *Aid for Women v. Foulston*, 441 F.3d 1101, 1126 (10th Cir. 2006) (citation omitted).

¹⁵⁵ See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 271 (1990).

¹⁵⁶ See *supra* note 11 and accompanying text.

situation while ensuring that physicians do not violate the ethical responsibilities of their profession.¹⁵⁷

Another state interest is the protection of “vulnerable groups.”¹⁵⁸ Victims of cardiac arrest, unconscious and on the verge of death, can confidently be classified as vulnerable.¹⁵⁹ Protecting these individuals from abuse is a legitimate state interest.¹⁶⁰ Although the physician who calls a patient’s time of death must not be the physician who removes or transplants his organs,¹⁶¹ competent medical professionals may have an interest in increasing organ donation rates, especially if they frequently care for other patients in need of organs. If a physician were permitted to call time of death earlier than the point at which it is physically impossible for a patient to be revived by any means, the practice could become fertile ground for abuse. The State here is reasonably interested in protecting the patient-victim.

Despite these legitimate interests, Virginia’s determination of death statute is not the least restrictive way to accomplish its objectives.¹⁶² This is apparent when one examines the criteria other states use to determine time of death.¹⁶³ Virginia could satisfy its goal of preserving life by adopting this prevalent standard. Once it is determined that an individual will not auto-resuscitate, and he also will not be treated with CPR, death is permanent. If Virginia accepts this as the time of death standard, it will succeed in both preserving life and allowing intended donors to maintain their privacy and self-definition. Further it will be sufficient to protect against internal abuses that may arise. Because this is a less restrictive means of achieving the preservation of life, Virginia’s compelling interest for prolonging the status quo does not outweigh the patients’ fundamental rights.

4. Constitutionality

The above due process analysis reveals that Virginia’s death-determination statute may seriously infringe fundamental privacy rights. While there may not exist a true privacy right in having one’s death declared at a certain time, Virginia’s statute

¹⁵⁷ The Hippocratic Oath requires doctors to help patients, not end their lives. *See* Peter Tyson, *The Hippocratic Oath Today*, PBS (Mar. 27, 2001), <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>.

¹⁵⁸ *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) (identifying the “poor, elderly, and disabled” as “vulnerable groups”; the latter two often comprise a significant portion of DCD donors).

¹⁵⁹ *See id.*

¹⁶⁰ *See Cruzan*, 497 U.S. at 261 (stating that a “State is entitled to guard against potential abuses” of patients unable to make their own decisions).

¹⁶¹ *See* UNIF. ANATOMICAL GIFT ACT § 8(b) (1987), 8A U.L.A. 58 (2003) (“[N]either the physician . . . who attends the donor at death nor the physician . . . who determines the time of death may participate in the procedures for removing or transplanting a part.”).

¹⁶² *See supra* notes 89–91 (citing cases articulating the Court’s requirement that regulations that infringe on fundamental rights be narrowly tailored).

¹⁶³ *See Harrington, supra* note 1, at 354–55.

encroaches on more than this. Death is declared for legal and record-keeping purposes. Deeming an individual “living” for a few minutes after he has passed away is not an infringement of a personal liberty; his body is not desecrated or disrespected. In fact, people are not declared dead until a medical professional calls the time of death. When individuals die in their homes, in many cases they are dead long before a doctor arrives and calls the time of death. This in itself does not violate a privacy right. The implications of the law are what stifle the right to privacy. These implications include loss of self-definition and the inability to proceed with organ donation in the most effective and safe manner possible.¹⁶⁴

Although Virginia’s statute would pass a rational basis review test¹⁶⁵—avoiding the harvesting of organs from living human beings is a legitimate state interest that would warrant infringement upon a non-fundamental right—the Commonwealth cannot establish the compelling interest and narrow tailoring required to justify the intrusion into personal privacy. For the reasons described above, Virginia’s statute is at odds with the Constitution of the United States.

B. Right to Die

1. Death as a Fundamental Right

In American jurisprudence, the right to death comprises a broad category of various interrelated personal liberties.¹⁶⁶ Included are the right to death itself, the right to define the manner of one’s own death, and the right to refuse means that will prolong life.¹⁶⁷ These have been subjects of national discussion and venerated by individuals claiming them as fundamental rights.¹⁶⁸ States’ interests in preserving life, however, are often directly at odds with these rights.¹⁶⁹ The Supreme Court has issued rulings on these questions with varying degrees of clarity.¹⁷⁰

¹⁶⁴ See *supra* Part II.B.

¹⁶⁵ See *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 (1938) (explaining that a law “is not to be pronounced unconstitutional unless . . . it is of such a character as to preclude the assumption that it rests upon some rational basis within the knowledge and experience of the legislators”).

¹⁶⁶ See generally *Vacco v. Quill*, 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Cruzan*, 497 U.S. at 280 (stating that it cannot be denied that states have an “interest in the protection and preservation of human life”).

¹⁷⁰ See *Vacco*, 521 U.S. at 808–09 (holding that states are permitted to prohibit physician-assisted suicide); *Glucksberg*, 521 U.S. at 705–06 (holding that individuals do not have the right to physician-assisted suicide); *Cruzan*, 497 U.S. at 262 (holding that individuals have the right to refuse life-saving medical treatment).

The right to death has most recently been contemplated with respect to the right to physician-assisted suicide.¹⁷¹ Terminally ill, competent, adult patients¹⁷² sometimes claim that they have the right to take their own lives in a humane manner.¹⁷³ This often requires the assistance of medical professionals. The rights alleged in such cases are typically a liberty interest in determining the “‘manner of one’s own death,’ . . . a ‘liberty to choose how to die,’ [and] a right to ‘control one’s final days.’”¹⁷⁴ The Supreme Court has considered these in several cases.¹⁷⁵

In *Vacco v. Quill*,¹⁷⁶ the Supreme Court addressed the issue of physician-assisted suicide, though the case was more of an equal protection inquiry, not a fundamental right determination.¹⁷⁷ It ruled that New York did not violate the Equal Protection Clause¹⁷⁸ in allowing terminally ill patients to end their lives by withdrawing life-sustaining equipment even though it did not permit other terminally ill patients to end their lives by participating in physician-assisted suicide.¹⁷⁹ Physicians who cared for terminally ill patients agreed the discrepancy seemed to treat patients differently based on whether they were using life-support machines.¹⁸⁰ The *Vacco* Court ruled, however, that there was no equal protection violation because all persons are

¹⁷¹ See generally *Glucksberg*, 521 U.S. 702.

¹⁷² Oregon, one of the three states that explicitly makes assisted suicide legal, governs it very strictly:

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner.

Oregon Death with Dignity Act, OR. REV. STAT. ANN. § 127.805 (2.01) (2011). The statute defines “terminal disease” to mean “an incurable and irreversible disease that . . . will . . . produce death within six months.” *Id.* at § 127.800 (1.01).

¹⁷³ Patients in Montana, Oregon, and Washington elect to terminate their lives every year. In Oregon, there were sixty-five physician-assisted suicides in 2010. OREGON PUBLIC HEALTH DIVISION, OREGON DEATH WITH DIGNITY ACT ANNUAL REPORT (2010), <http://www.oregon.gov/DHS/ph/pas/>. At least thirty-six patients in Washington elected physician-assisted suicide that same year. William Yardley, *Report Finds 36 Died Under Assisted Suicide Law*, N.Y. TIMES, Mar. 4, 2010, <http://www.nytimes.com/2010/03/05/us/05suicide.html>. Montana does not have statistics yet because assisted suicide just became legal in late 2009. See Kirk Johnson, *Montana Ruling Bolsters Doctor-Assisted Suicide*, N.Y. TIMES, Jan. 1, 2010, <http://www.nytimes.com/2010/01/01/us/01suicide.html>.

¹⁷⁴ *Glucksberg*, 521 U.S. at 703.

¹⁷⁵ See generally *Vacco*, 521 U.S. 793; *Glucksberg*, 521 U.S. 702.

¹⁷⁶ 521 U.S. 793 (1997).

¹⁷⁷ *Id.* at 793.

¹⁷⁸ U.S. CONST. amend. XIV, § 1 (“No state shall . . . deny to any person within its jurisdiction the equal protection of the laws.”).

¹⁷⁹ *Vacco*, 521 U.S. at 808–09.

¹⁸⁰ *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996) (holding that the disparities in access to death violated equal protection), *overruled by Vacco*, 521 U.S. 793.

afforded the same opportunities: everyone is permitted to refuse treatment, and no one is permitted to receive help from a physician in committing a suicide.¹⁸¹

Unfortunately, the more relevant issue—the legality of euthanasia—did not receive the same limelight as the Equal Protection inquiry. The *Vacco* Court did not address whether terminally ill, competent individuals have the right to a physician’s assistance in committing suicide.¹⁸² The Court never held, therefore, that there is no right to death,¹⁸³ preserving the issue for future analysis.

Washington v. Glucksberg, Vacco’s companion case, targeted the “right to death” issue more narrowly.¹⁸⁴ The question the Court sought to answer was “whether the ‘liberty’ specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.”¹⁸⁵ Though plaintiffs convinced the district¹⁸⁶ and circuit¹⁸⁷ courts that the right to die by suicide with the help of a physician is a fundamental right, the Supreme Court did not find this concept consistent with the United States’s history and traditions.¹⁸⁸ Therefore, the Court found no right to physician-assisted suicide, and thus no absolute right to die.¹⁸⁹

The possibility of a right to assistance in suicide, however, is not foreclosed entirely. Justice Stevens, in his concurrence in *Glucksberg*, discerned that “some applications of the [assisted suicide ban] may impose an intolerable intrusion on the patient’s freedom.”¹⁹⁰ Though Stevens believed the facts of the *Glucksberg* and *Vacco* cases did not warrant a right to assisted suicide, he wrote that different circumstances might.¹⁹¹ Specifically, he noted that the state interest in preserving life “is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient’s dignity and alleviating her intolerable suffering.”¹⁹² Therefore, the right to physician-assisted suicide for patients meeting certain qualifications cannot be dismissed entirely. In fact, Washington has since legalized physician-assisted suicide.¹⁹³

¹⁸¹ *Vacco*, 521 U.S. at 800.

¹⁸² *See generally id.*, 521 U.S. at 793.

¹⁸³ *Id.*

¹⁸⁴ *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997) (describing how the interest at stake must be carefully formulated).

¹⁸⁵ *Id.* at 736 (O’Connor, J., concurring).

¹⁸⁶ *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *overruled by Glucksberg*, 521 U.S. 702.

¹⁸⁷ *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *overruled by Glucksberg*, 521 U.S. 702.

¹⁸⁸ *Glucksberg*, 521 U.S. at 710 (stating that “an examination of our Nation’s history, legal traditions, and practices demonstrates that Anglo-American common law has punished or otherwise disapproved of assisting suicide for over 700 years”); *see also id.* at 710–19.

¹⁸⁹ *Glucksberg*, 521 U.S. at 702.

¹⁹⁰ *Id.* at 751–52 (Stevens, J., concurring).

¹⁹¹ *Id.* at 752.

¹⁹² *Id.*

¹⁹³ Washington Death with Dignity Act, WASH. REV. CODE ANN. § 70.245.040 (2011).

The right to refuse medical treatment, and thus to be allowed to die, also fits the broad “right to death” category. Unlike the denial of a fundamental liberty interest in assisted suicide,¹⁹⁴ the Supreme Court has explicitly declared the refusal of life-sustaining medical treatment a fundamental right under the United States Constitution.¹⁹⁵ In *Cruzan*, the Supreme Court used previous decisions as guides to determine that a “competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.”¹⁹⁶ Withdrawing life support and passively allowing natural events to occur is distinct from actively causing an individual to die.¹⁹⁷ This is how *Glucksberg* and *Vacco* distinguished the physician-assisted suicide issue from the passive death issue in *Cruzan*.¹⁹⁸

Complementary to both the right to refuse medical treatment and the right to die is the claimed right to determine the manner of one’s own death. The appellate court in *Glucksberg* found such a right in *Casey* and *Cruzan*.¹⁹⁹ Although this does not apply authoritatively to the present case, it demonstrates an additional application of the liberties inherent in an overarching right to death.

The Supreme Court has deemed fundamental several aspects of the liberty interest in ending one’s own life. Though not embraced to the furthest reaches of the imagination, the Court is willing to protect an individual’s right to die in certain circumstances.²⁰⁰

2. Death in Organ Donation

The right to death and its corresponding liberties play an important role in the examination of the constitutionality of Virginia’s death-determination law. The law requires that, prior to declaring that an individual is dead, it must be of the physician’s opinion that the patient could not be resuscitated with CPR.²⁰¹ In determining when the individual in question is deceased, Virginia’s statute also determines when he no longer has the rights of a United States citizen.²⁰² For this reason, the question of

¹⁹⁴ See *Vacco v. Quill*, 521 U.S. 793 (1997); *Glucksberg*, 521 U.S. 702.

¹⁹⁵ *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

¹⁹⁶ *Id.* at 278.

¹⁹⁷ See *Vacco*, 521 U.S. at 798 (noting the difference between “allowing nature to take its course” and “intentionally using an artificial death-producing device”).

¹⁹⁸ *Id.*, 521 U.S. at 801 (stating that “when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication”).

¹⁹⁹ *Compassion in Dying v. Washington*, 79 F.3d 790, 816 (9th Cir. 1996), *overruled by Washington v. Glucksberg*, 521 U.S. 702 (1997) (stating that these cases “provide persuasive evidence that the Constitution encompasses a due process liberty interest in controlling the time and manner of one’s death—that there is, in short, a constitutionally recognized ‘right to die’”).

²⁰⁰ See, e.g., *Cruzan*, 497 U.S. 261.

²⁰¹ VA. CODE ANN. § 54.1-2972(A)(1) (2010 & Supp. 2011).

²⁰² See *id.*; see also Erik S. Jaffe, Note, “*She’s Got Bette Davis[’s] Eyes*”: Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses,

when an individual is pronounced dead is important. Though this has little impact on the lives—and on the deaths—of most individuals, the Virginia law has weighty ramifications when the dying individual has expressed wishes that are tied to and dependent on the declaration of his death, such as organ donation.²⁰³

The specific “right” invoked in such a situation is not the right to be allowed to die. Instead, it is the right to be pronounced dead when one is actually dead. This falls into the same broad “right to death” category of personal liberties discussed in the previous subsection. Though material controversy exists as to when an individual can be said to have officially died,²⁰⁴ other states have been able to make determinations more in harmony with the deceased’s interests than Virginia has been.²⁰⁵ The question is whether, when an individual has issued a DNR order and enters cardiac arrest, his death should be reckoned by the cessation of his vital signs without regard to whether mechanical resuscitation would revive him. Because he has expressly denied a desire to be resuscitated, it is his right to be declared dead without taking the effects of CPR into account. Most states interpret the UDDA as providing exactly this.²⁰⁶ A declaration of death at the moment cardiovascular function will not resume is indeed a reasonable standard for pronouncing death.

The present question can be distinguished from that in *Vacco v. Quill*. In *Vacco*, the Supreme Court made a distinction between the removal of life-sustaining treatment and physician-assisted suicide.²⁰⁷ One factor they used to draw a line between the two is the fact that, in the former, the physician is only stopping treatment the patient no longer finds helpful.²⁰⁸ By contrast, in the latter, the doctor unnaturally causes the patient to die.²⁰⁹ A declaration of death upon irreversible failure of cardiopulmonary function sans CPR criterion is akin to forgoing unwanted treatment. A physician who declares death when cardiopulmonary function irreversibly ceases without regard to CPR is not intending for the patient to die; he is simply declaring the time of death when it naturally occurs. This is far more similar to the protected practice of refusing medical treatment than it is to physician-assisted suicide. Declaring death when the patient would have wanted death to be declared does not cause or even hasten death, as it did for the patients at issue in *Vacco*.²¹⁰ Death occurs at the same point, regardless of when the physician declares it formally.

90 COLUM. L. REV. 528 (1990) (discussing the relative rights of the living and deceased to control access to their bodies).

²⁰³ Harvesting of organs for transplant must occur as quickly as possible to avoid deterioration from warm ischemia. See *supra* notes 1, 15 and accompanying text.

²⁰⁴ Goldsmith, *supra* note 12, at 917–18.

²⁰⁵ Harrington, *supra* note 1, at 354–55.

²⁰⁶ *Id.*

²⁰⁷ *Vacco v. Quill*, 521 U.S. 793, 801 (1997).

²⁰⁸ *Id.*

²⁰⁹ *Id.* at 802.

²¹⁰ *Id.* at 801.

Additionally, individuals enter DNR orders because they do not wish to be resuscitated; like those who refuse medical treatment, they wish to be left at peace when their bodies can no longer naturally sustain them. Waiting to call time of death until after a physician determines that CPR would be ineffective is contrary to the patient’s interest in being left at peace.²¹¹ This intent theme also rings true with organ donors, who intend to maximize the goodwill stemming from their gifts. A hospitalized organ donor who issues a DNR order intends to donate his organs in a manner that will, in fact, maximize this goodwill.²¹² The patient does not intend for the physician to delay a donation, risking the quality of his organs, in order to declare that CPR would not resuscitate him when he never intended for CPR to be performed anyway. The patient would not “stand[] to benefit from” this determination that treatment would no longer be effective.²¹³ Like the physicians in *Cruzan*, Virginia physicians should be permitted to act in the patient’s best interests with the patient’s intent in mind.

Furthermore, just because it is permissible to ban physician-assisted suicide does not mean it must be banned. Justice Stevens’s concurrence in *Glucksberg* left physician-assisted suicide open for a later determination that some instances may be protected by right, but ruled that a state’s ban was not unconstitutional given the facts of the case being considered.²¹⁴ Thus, even if a more proximate death determination fit the analysis of *Glucksberg*, its legality deserves careful consideration. The present situation much more strongly resembles the facts of *Cruzan* than *Glucksberg*; in *Cruzan*, refusal of medical treatment was deemed a fundamental right.²¹⁵ It is not something to be left to decide later; the Court already made its decision. This distinction between killing oneself and removing artificial means of life support is recognized by many courts²¹⁶ and state legislatures.²¹⁷

The present issue in many ways parallels the issue faced by the Justices in *Cruzan*. The *Cruzan* Court held that a sick individual whose life is sustained by machines can terminate this treatment, even though it will necessarily result in death.²¹⁸

²¹¹ The Court in *Vacco* stated that the right to refuse treatment, laid out in *Cruzan*, was grounded “on well-established, traditional rights to bodily integrity and freedom from unwanted touching.” *Id.* at 807 (citing *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278–79 (1990)).

²¹² In the United States, organ donation is an opt-in system; it requires consent of the donor. See UNIF. ANATOMICAL GIFT ACT § 2(b) (1987), 8A U.L.A. 24 (2003) (“An anatomical gift may be made only by a document of gift signed by the donor.”).

²¹³ See *Vacco*, 521 U.S. at 801 (quoting *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 104th Cong. 368 (1996) (testimony of Dr. Leon R. Kass)).

²¹⁴ *Washington v. Glucksberg*, 521 U.S. 702, 751–52 (1997) (Stevens, J., concurring).

²¹⁵ *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

²¹⁶ *Vacco*, 521 U.S. at 803 (“[M]any courts . . . have carefully distinguished refusing life-sustaining treatment from suicide.”).

²¹⁷ *Id.* at 804–05 (stating that “the overwhelming majority of state legislatures” have made such a distinction).

²¹⁸ *Cruzan*, 497 U.S. 261.

Applying this to the present issue, a DNR patient who experiences cardiac arrest in Virginia may remain free of life-saving medical equipment and be allowed to expire. A law that interferes with the patient's ability to refuse life-saving treatment would be unconstitutional.²¹⁹ Accordingly, the Virginia law in question does not require or even allow physicians to force life-sustaining treatments on patients.²²⁰ Instead, it demands that physicians delay a death determination until after the window of time when life-sustaining treatments would be effective elapses.²²¹ The difficulty lies in ascertaining whether this is similar enough to forcing life-sustaining treatments on a patient against his will.

Full judicial scrutiny of the Virginia law mandates more than a comparison to other cases; the law must survive history/tradition- and implicit-in-ordered-liberty analyses.²²² Similar to the results of this inquiry in the privacy subsection above,²²³ the constitutionality of death statutes like Virginia's is not well-established in American jurisprudence. The return to DCD introduced new ethical and scientific questions into the law;²²⁴ its absence in legal thought at present is thus warranted. No one has considered whether it violates a fundamental right if a state delays an organ donor's determination of death based on the use of a procedure to which the deceased has indicated an aversion. The two most relevant Supreme Court cases are *Glucksberg* and *Cruzan*. In *Glucksberg*, the history and tradition analysis of physician-assisted suicide failed because of the Western world's contempt for suicide.²²⁵ Thus, the "right" to death discussed in *Glucksberg* does not exist because it is death attained in an historically illegal manner. The present issue—the right to be declared dead when one's cardiopulmonary function will never be revived spontaneously—is distinct from claiming a right to suicide. It is more akin to allowing natural consequences to take place. This is more historically acceptable, and it is the right that was upheld in *Cruzan*.²²⁶

It is clear that removal of unwanted life-sustaining measures is a fundamental right.²²⁷ Assistance in suicide, however, is—for the time being—not.²²⁸ A declaration of death when one is no longer living falls somewhere in the middle of this spectrum. In distinguishing *Cruzan* from *Glucksberg*, the Supreme Court relied heavily on the cause of death of the individual asserting the liberty interest.²²⁹ When a DNR individual

²¹⁹ *See id.*

²²⁰ *See* VA. CODE ANN. § 54.1-2972(A)(1) (2010 & Supp. 2011).

²²¹ *Id.*

²²² *See* *Washington v. Glucksberg*, 521 U.S. 702, 710 (noting that all "due process cases" begin "by examining our Nation's history, legal traditions, and practices").

²²³ *See supra* Part III.A.2.

²²⁴ *See supra* Part I.B.

²²⁵ *Glucksberg*, 521 U.S. at 710.

²²⁶ *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

²²⁷ *Id.*

²²⁸ *Glucksberg*, 521 U.S. 702.

²²⁹ *See Cruzan*, 497 U.S. at 281 (holding that the Constitution protects a right to refuse medical treatment, not the right to end one's own life); *Vacco v. Quill*, 521 U.S. 793, 797

asserts the right to be declared dead when his body can no longer survive without resuscitation, he is essentially asking that nothing be done to revive his dying body. He is not asking for a doctor to assist or hasten his death. His right should be treated more like that expressed in *Cruzan* than that in *Glucksberg*. The Supreme Court, if confronted with such an issue, would likely rule that the DNR individual has a fundamental right to know his body will not be tampered with after cardiopulmonary function is irreversibly lost. Whether the Court would extend this right to prohibit physicians from using artificial resuscitation criteria in determining the cause of death is beyond the scope of precedent, but it is arguable that it would. In so doing, the Court would be pronouncing a new—and needed—fundamental right.

3. Compelling Interest

For Virginia’s declaration of death law to be constitutional, the Commonwealth must have a compelling interest in infringing on the fundamental right to death.²³⁰ Of the frequently cited compelling interests, those applicable here include preservation of life, protection of third parties, and upholding the integrity of the medical profession.²³¹ The legislative intent for this particular component of Virginia’s law is not recorded. One might infer, however, that the legislature intended to protect individuals from a premature declaration of death. Although not noted in legislative reports or session minutes, requiring a procedure for determining death indicates a desire to control and regulate when it occurs. Virginia wanted to ensure that death is only declared when death has in fact occurred. Debate on the specified death-determination procedure itself is not apparent from the legislative materials; the ramifications of the terminology used may not have been intended. Despite the uncertainty, it is safe to assume, at the very least, that Virginia seeks to protect life.

Spontaneous resuscitation after the cessation of cardiopulmonary functions is very rare, but it is possible.²³² Physicians are acting safely when they wait to declare death until even machines could not resuscitate the patient. Though legislators might not have drafted this law with a mind toward organ donation, it certainly seeks to protect life in the organ donation context. Removing organs before a patient is dead would certainly kill him. Furthermore, the dead donor rule requires that organ donors be dead before vital organs are removed.²³³ The rule’s purpose is twofold: it protects

(1997) (noting the difference between “allowing nature to take its course” and “intentionally using an artificial death-producing device”).

²³⁰ *Roe v. Wade*, 410 U.S. 113, 155 (1973) (“Where certain ‘fundamental rights’ are involved, the Court has held that regulation limiting these rights may be justified only by a ‘compelling state interest’”) (citations omitted).

²³¹ *See Cruzan*, 497 U.S. at 271.

²³² *See Bernat*, *supra* note 37, at 671 (stating that the longest interval after which a human auto-resuscitated was one minute).

²³³ *See supra* note 11 and accompanying text.

the donor's bodily integrity by not removing his organs while he is still alive, and prevents the organ harvesting from causing the donor's death.²³⁴ This justifies Virginia's interest in governing death determinations. In fact, the Supreme Court has deemed health and safety compelling interests in the past.²³⁵

Virginia's law also protects third parties. It eliminates the possibility that family members might be told their loved one is dead only to see him revived later. But, as described above, spontaneous resuscitation is a remote possibility.²³⁶ Most of the time, delaying such a declaration does not negatively impact the deceased or his family, as it is not often apparent whether cessation of cardiopulmonary function is permanent or impermanent.²³⁷ In cases where the deceased is an organ donor, however, the delay can be detrimental.²³⁸ It is hardly compelling for a state to enact a law that, though admittedly in most situations will not provide any problems, may interfere with the intent and wishes of a deceased individual. An alternative law could provide the same benefits without the negative consequences.²³⁹

The final potential compelling interest Virginia could assert is the preservation of the virtues of the medical profession. Most physicians abide by medical ethics, swearing to "do no harm."²⁴⁰ Injury to potential organ donors by premature harvesting, as discussed above, constitutes harm. Virginia's law, therefore, protects the integrity of physicians by ensuring certain standards are met. This cuts both ways, however. Physicians are also required to respect the autonomy of their patients, including their end-of-life decisions.²⁴¹ Furthermore, although the physician who declares the time of death cannot be the same physician who has an interest in implanting the deceased's organs in another patient,²⁴² the medical profession as a whole has an interest in saving lives through organ donation.²⁴³ Virginia's death-determination law unnecessarily

²³⁴ *Id.*

²³⁵ *See, e.g., Cruzan*, 497 U.S. at 271, 279–80.

²³⁶ *See* Bernat, *supra* note 37, at 671.

²³⁷ *See supra* Part II for a discussion of the debates regarding irreversibility of cardiopulmonary cessation.

²³⁸ *See* Harrington, *supra* note 1, at 340.

²³⁹ *See supra* text accompanying notes 55–63.

²⁴⁰ The principle of nonmaleficence asserts an obligation not to inflict harm on others. In medical ethics it has been closely associated with the maxim *Primum non nocere*: "Above all [or first] do no harm." Health care professionals frequently invoke this maxim. . . . [T]he Hippocratic Oath clearly expresses an obligation of nonmaleficence.

TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 113 (5th ed. 2001) (first alteration in original).

²⁴¹ *See generally id.* for a discussion of the principle of patient autonomy in medical ethics.

²⁴² *See* UNIF. ANATOMICAL GIFT ACT § 8(b) (1987), 8A U.L.A. 58 (2003) (barring conflicts of interest by forbidding physicians from declaring death who have an interest in implanting the organ).

²⁴³ *See* OPPORTUNITIES FOR ACTION, *supra* note 6, at 46 (describing the "widening gap between the supply of transplantable organs and the number of patients on the waiting list").

delays the call of death, which sacrifices the probability of organ donation success. It is therefore reasonable to conclude that the integrity of the medical profession is injured by Virginia’s current law.

Even though Virginia’s interest may be compelling in at least one instance—preservation of life—in order for it to abrogate the plausibly fundamental right to an honest death declaration, the law must be the least restrictive way to accomplish the state’s objective.²⁴⁴ Although it is certainly not the most restrictive,²⁴⁵ other methods exist—and are quite popular—for realizing state health objectives without interfering as heavily with personal liberties.²⁴⁶ The law therefore fails the compelling interest component of the due process analysis.

4. Constitutionality

Virginia’s law compromises a form of the fundamental right to death; as such, the Commonwealth must have a compelling reason to justify it. Though Virginia has a strong interest in the preservation of life, and this is a sufficiently compelling reason, the law Virginia enacted is not the least restrictive way to achieve this objective.

The Institute of Medicine’s interpretation of the UDDA embraces the states’ interests in the preservation of life and the safety of the patient, but it is more narrowly tailored.²⁴⁷ It also provides for the rights of the deceased individual.²⁴⁸ Perhaps this is why most states adhere to some version of its test.²⁴⁹ Removing CPR from the analysis of when a DNR individual is dead satisfies both state and citizen interests. Additionally, it provides for increased uniformity, which enhances the function of such a rule, ensuring predictability and consistency. Virginia’s law, based on this analysis, is unconstitutional.

IV. RECOMMENDATIONS

A. Joining the Majority

Virginia should modify its death-determination statute to conform with those of the majority of states.²⁵⁰ For DNR patients, “irreversible” death should mean that a patient will not spontaneously resuscitate. Legislation should be drafted that would

²⁴⁴ See *Roe v. Wade*, 410 U.S. 113, 155 (1973) (stating that when fundamental rights are involved, “legislative enactments must be narrowly drawn to express only the legitimate state interests at stake”).

²⁴⁵ See OKLA. STAT. ANN. tit. 63, § 3122 (West 2011) (requiring that a physician unsuccessfully attempt to resuscitate a patient in cardiac arrest before declaring death).

²⁴⁶ See Harrington, *supra* note 1, at 354; see also *supra* Part II.A.

²⁴⁷ See *supra* Part II.A–B.

²⁴⁸ See *supra* Part II.A.

²⁴⁹ See *supra* Part II.A.

²⁵⁰ See *supra* Part II.A.

nullify Virginia's current death-determination criteria and use language that does not consider the effectiveness of artificial resuscitation when a patient has expressly rejected that course of treatment.

B. Public Policy

In addition to the unconstitutionality of Virginia's current law, many policy reasons also dictate a change in the statute. Such rationales include a tradition of respecting the deceased's wishes, uniformity, maintaining consent when patients die in states other than their own, and increasing the benefit to society by providing for more possible organ donations.

In the United States, most people have a strong respect for the deceased.²⁵¹ Although no property interest exists in dead bodies,²⁵² family members are legally entitled to ensure no desecration of the corpse occurs.²⁵³ Additionally, much reverence is paid to the final wishes of the deceased.²⁵⁴ Wills and testaments are honored when they are legal and binding.²⁵⁵ The intent of an individual to give his estate to a particular person is similar to his intent to give his organs to a needy recipient. "Although a body is not 'property' that can pass under a will, courts have nevertheless enforced the clearly expressed wishes of testators as to the dispositions of their bodies."²⁵⁶

When an intended organ donor passes away, his express donation wish also should be honored. It is true that not all transplantations will be successful, even when doctors do their best and all variables are favorable.²⁵⁷ It is also expected and justifiable for the organ harvesting and transplantation process to be governed by rules ensuring safety to all parties involved.²⁵⁸ Unnecessary regulations that restrain

²⁵¹ See Youngner & Arnold, *supra* note 11, at 2770.

²⁵² See *supra* note 148.

²⁵³ See *supra* notes 141, 145–46 and accompanying text.

²⁵⁴ See *supra* note 145.

²⁵⁵ GORDON BROWN & SCOTT MYERS, ADMINISTRATION OF WILLS, TRUSTS AND ESTATES 9 (3d ed. 2003) ("[T]he right to leave property by will is not an inherent right, but a privilege permitted by law . . . Each state has its own laws . . . setting forth the disposition of property by will.").

²⁵⁶ Mark E. Wojcik, *Discrimination After Death*, 53 OKLA. L. REV. 389, 431 (2000).

²⁵⁷ See HEALTH RES. AND SERVS. ADMIN., U.S. DEPT. OF HEALTH & HUMAN SERVS., 2009 OPTN/SRTR ANNUAL REPORT tbl.I-6, available at http://optn.transplant.hrsa.gov/ar2009/chapter_i_AR_cd.htm?cp=2 (charting the 2007 patient survival rates by organ, which are eighty percent for lungs, eighty-eight percent for heart, eighty-six to eighty-seven percent for liver, and seventy-five percent for intestines).

²⁵⁸ See INST. OF MED., ORGAN PROCUREMENT AND TRANSPLANTATION: ASSESSING CURRENT POLICIES AND THE POTENTIAL IMPACT OF THE DHHS FINAL RULE 22, at 14 (1999), available at http://www.nap.edu/catalog.php?record_id=9628 [hereinafter IOM REPORT 1999] (recommending that there should be established an "external, independent, multidisciplinary scientific review board . . . ensuring that the system of organ procurement and transplantation is grounded on the best available medical science and is as effective and as equitable as possible").

the success of the donation procedure, however, directly contradict the will of the intended donor. Because society traditionally respects the reasonable wishes of the deceased, it is contrary to public policy to maintain a law such as Virginia’s death-determination statute.

Public benefits also accrue when laws of this nature are uniform throughout the nation. Much uniformity has already materialized with respect to organ donation. The Uniform Anatomical Gift Act (UAGA),²⁵⁹ for example, contains procedures and guidelines for every aspect of the organ donation process.²⁶⁰ To date, forty-four states and the District of Columbia have enacted the UAGA.²⁶¹ The UAGA Committee Chairman reports that “the Act brings needed uniformity where minutes are too precious to permit wasting time deciphering divergence in state laws.”²⁶² Thus, one discernible advantage of state uniformity is the time saved in eliminating a sift through nuances in different jurisdictions’ statutes, which ultimately leads to greater success in transplantation. This will inevitably lead to another advantage—fewer mistakes. When physicians and hospitals are aware of precise protocol and their thinking is not obscured by the muddled array of varying state practices, they will perform more confidently and with greater accuracy. This will result in fewer instances of error, which can have tragic consequences when life is at stake.

The United Network for Organ Sharing (UNOS) is another product of organ donation unification. In 1984, the federal government passed the National Organ Transplant Act.²⁶³ This Act created the Organ Procurement and Transplantation Network,²⁶⁴ which is administered by UNOS through a contract with the Department of Health and Human Services.²⁶⁵ UNOS manages the national transplant waiting list and organ transplant data.²⁶⁶ It has a nationwide system that promotes unified goals such as maximizing transplantable organs, maximizing donee survival, and minimizing deaths that occur because transplants are not available, among many others.²⁶⁷

The IOM also believes uniformity in organ donation is important. In a report released in 1999, it recommended that the federal government exercise even more

²⁵⁹ UNIF. ANATOMICAL GIFT ACT (1987), 8A U.L.A. 3 (2003).

²⁶⁰ *Id.* at §§ 2–10.

²⁶¹ See *Uniform Anatomical Gift Act Enactment Status Map*, UNIFORM LAW COMMISSION, [http://www.nccusl.org/Act.aspx?title=Anatomical Gift Act \(2006\)](http://www.nccusl.org/Act.aspx?title=Anatomical%20Gift%20Act%20(2006)) (last visited Mar. 15, 2012). The bill is presently pending in Massachusetts and Pennsylvania. *Id.*

²⁶² Steve Ferkau, *Way to go Wisconsin!!!!*, REVIVE HOPE (Aug. 8, 2008), http://revivehope.typepad.com/revive_hope/2008/08/way-to-go-wisco.html.

²⁶³ 42 U.S.C. § 274 (2011).

²⁶⁴ *Id.*

²⁶⁵ *About OPTN*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, U.S. DEPT. OF HEALTH & HUMAN SERVS., <http://optn.transplant.hrsa.gov/optn/> (last visited Mar. 15, 2012).

²⁶⁶ *About Us*, UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org/about/index.php> (last visited Mar. 15, 2012).

²⁶⁷ *UNOS Rationale for Objectives of Equitable Organ Allocation*, UNITED NETWORK FOR ORGAN SHARING (Jan. 15, 1996), http://www.unos.org/about/index.php?topic=newsroom&article_id=1503:85b3dc451eb0ded52b3121dc59c438dc (listing UNOS’s objectives).

oversight.²⁶⁸ It stated, “The federal government, as well as the transplantation community, has a legitimate and appropriate role to play in ensuring that the organ procurement and transplantation system serves the public interest, especially the needs and concerns of patients, donors, and families affected by it.”²⁶⁹ Thus, uniformity also serves the public interest.

The benefits secured from this homogeneity among states can also be realized by achieving consistency with respect to state death-determination laws. The determination of death is so intrinsically linked to organ donation that the reasons for supporting national uniformity regarding organ donation also generate a strong argument for standardizing death-determination laws. Additionally, consistency is already sought with regard to death determination, as apparent from the widespread acceptance of the UDDA.²⁷⁰

Uniformity also helps keep consent intact, another benefit to be gained from amending Virginia’s current death-determination statute. Because organ donation is a personal, significant decision, uniformity in interpretation of what exactly it entails is very important. Organs are usually harvested in the state in which an individual dies.²⁷¹ If an individual designates in one state that he is an organ donor, and then is near death in a Virginia hospital, the harvesting procedure would be dependent on his time of death as determined by Virginia law. The problem is that he consented to organ donation as it operates in the state from which he came. He authorized a medical procedure involving immediate harvesting upon death, not harvesting a substantial amount of time after he became irreversibly dead. It is questionable whether the patient’s previous consent applies in this situation.

Perhaps the most important public policy rationale for refashioning Virginia’s death statute is the societal gain that will flow from an increased number of successful organ donations. Throughout the country, demand for organs excessively outweighs supply.²⁷² Because the effects of warm ischemia are known, it is scientifically proven that organ transplantations are more successful when the organs receive blood and oxygen for as long as possible.²⁷³ Delaying a call of death delays harvesting, which increases the time the organs are deprived of blood and oxygen. This decreases the overall likelihood of transplantation success. In a medical procedure where fractions of minutes are precious, a risk that has no real benefits should not be taken.

²⁶⁸ IOM REPORT 1999, *supra* note 258, at 133.

²⁶⁹ *Id.* at 131.

²⁷⁰ *See supra* notes 29–30 and accompanying text.

²⁷¹ *See generally* Harrington, *supra* note 1, at 340, 344–45 (describing how warm ischemia time “diminish[es] the quality of the organs for transplantation” and how organs rapidly deteriorate after cardiac arrest).

²⁷² OPPORTUNITIES FOR ACTION, *supra* note 6, at 46.

²⁷³ *See* Bernat, *supra* note 37, at 671 (stating that “the sooner death can be declared after asystole, the less damage from warm ischemia will occur in the organs”); Harrington, *supra* note 1, at 342 (“[T]he quality of organs recovered from brain-dead, heart-beating donors was vastly superior to organs impaired by the warm ischemia time associated with circulatory death.”).

CONCLUSION

Throughout history, Americans have come to learn that many legal problems are generated by the conflict between their own opinions and those of the state. Contentions are compounded when factors beyond personal desires serve to counter state interests—factors such as science, economics, and utilitarianism. Technological advancements unforeseeable to the nation’s Founders complicate matters even further, and what is left can be a seemingly unsolvable ethical, philosophical, and legal dilemma.

Privacy and death rights, though deep-rooted in United States jurisprudence, have assumed evolving definitions in more recent decades as medical technology has progressed. Without any categorical interpretation, states resort to their own interpretations of constitutional law and scientific recommendations, often resulting in different constraints and liberties across jurisdictions, even when attempts at uniformity are undertaken. Virginia’s death-determination statute exemplifies this conundrum. In contexts like organ donation, Virginia’s approach to a determination-of-death statute implicates issues of privacy, personal autonomy, and the right to die. Virginia stands out against most other states in its definition of death and infringes upon personal liberties in situations involving the non-heart-beating donor method of organ transplantation. Though Virginia is justified in seeking to preserve life with this statute, its restrictions could be more narrowly tailored, thus rendering the law unconstitutional.

In addition to the due process violation, policy reasons in line with state interests, such as societal gain and respecting the wishes of the deceased, dictate a departure from Virginia’s legal standard. Virginia’s legislature should examine the law under closer scrutiny to determine how gravely it infringes on the fundamental rights to death and privacy or whether it is otherwise contrary to public policy. Either way, the clock has ticked long enough; it is time for Virginia to wake up and critically assess and reform its death-determination statute.