Advance Medical Directives in West Virginia, Part One

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ADVANCE MEDICAL DIRECTIVES IN WEST VIRGINIA, PART ONE

IRENE M. KEELEY*

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I. INTRODUCTION

Public awareness about an individual's right to appoint a surrogate to decide whether to forego life-prolonging medical care has increased dramatically since the United States Supreme Court, in Cruzan v. Director, Missouri Dep't of Health, decided that the United States Constitution "would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."1 By a 5-4 margin, however, the Court affirmed that the state

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In Cruzan, eight justices, all except Antonin Scalia, affirmed that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. Cruzan, 110 S. Ct. at 2851 (citing Jacobson v. Massachusetts, 197 U.S. 11 (1905)). Justice Rehnquist, writing for the majority, found no requirement in the Constitution to repose a right of substituted judgment with anyone. "But we do not think the Due Process Clause requires the state to repose judgment on these matters with anyone but the patient herself . . . . [T]he state may choose to defer only to those wishes, rather than confide the decision to close family members." Cruzan, 110 S. Ct. at 2855-56.

The concurring opinion of Justice O'Connor, however, recognized the utility and appropriateness of surrogate decisionmaking through advance directives such as living wills and health care powers of attorney.

These procedures for surrogate decision-making, which appear to be rapidly gaining in acceptance, may be a valuable additional safeguard of the patient's interest in directing his medical care . . . . Today's decision . . . does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed...
of Missouri could require Nancy Cruzan, a 33-year-old woman who had been in a persistent vegetative state for more than seven years,\(^2\) to be maintained by a gastrostomy feeding and hydration tube because her parents, acting as her committee, had not shown by "clear and convincing" evidence that she would have wanted the treatment stopped.

Nancy Cruzan's plight is not unique. In 1988, the year the Supreme Court of Missouri refused to permit the withdrawal of life support as directed by Nancy Cruzan's parents, as many as 10,000 patients in the United States were diagnosed to be in a persistent vegetative state.\(^3\)

Decisions to withhold or withdraw life-prolonging intervention for such patients generally have been made privately by the patient, family, and physician in American hospitals. It has been the rare case that has surfaced to be decided by the courts.\(^4\) That medical decisions concerning termination of treatment at the end of life are usually made privately does not, however, indicate that such decision-making is without controversy.\(^5\)

surrogate.

\(^2\) Nancy Cruzan had been in a car accident in 1983, as a consequence of which she had been deprived of oxygen for 12-14 minutes. Permanent brain damage generally results six minutes in an anoxic (oxygen-deprived) state. See Cruzan, 110 S. Ct. at 2844-45.


\(^4\) Brief for American Hospital Ass'n as Amicus Curiae in Support of Petitioners at 2-3, Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990).

\(^5\) In fact, such controversy has generated a new eponym in the field of medical ethics: "Wanglie, a person, most often in a persistent vegetative state, for whom there is disagreement between the physician and family on the appropriateness of continued treatment." American Hospital Association, Recent Court Decisions Show Wide Range of Rulings on Futility, 7 Hosp. ETHICS 1 (1991) [hereinafter Recent Court Decisions]. Helga Wanglie was a severely brain-damaged, 87-year-old woman in a persistent vegetative state whose husband insisted she be maintained on a ventilator for oxygen and a feeding tube for nutrition. The Hennepin County Hospital in Minneapolis, Minn. sought a court order to turn off Mrs. Wanglie's life support system because the physicians attending her viewed the treatment as futile. See id. at 5.
Long before the *Cruzan* decision left the issue of how to regulate an incapacitated patient’s right to be free of unwanted medical treatment up to the “laboratory” of the states, many state courts and legislatures had begun wrestling with this complex question through a variety of judicial and legislative solutions. Following *Cruzan*, the states have moved aggressively to enact so-called “advance directive” statutes. Several states have amended earlier legislative solutions, such as living will statutes, to specifically include patients in a persistent vegetative state. Others have enacted durable health care or medical power of attorney laws. Still others have adopted surrogate/family decisionmaking provisions that authorize certain individuals to make treatment decisions on behalf of incapable patients who have not left specific written or oral instructions.

Advance directives imperfectly project the decisions an individual would make during a period of incapacity. The living will is limited in its applicability to situations of terminal illness or the persistent vegetative state and only permits a patient to tell a physician what care is not wanted. It is not designed to provide guidance when a patient temporarily loses capacity during an acute illness. Moreover, the living will may lose currency if it is not updated as the individual’s situation changes — the directives of a thirty-year-old may differ substantially from those of an eighty-year-old.

The medical power of attorney, although far preferable to the living will because the appointment of a representative to make medical decisions gives health care providers access to an individual who can react to changing clinical circumstances, is not without its shortcomings. The representative may not be available, or may be emotionally conflicted when the principal’s wishes are unknown or the family objects to the patient’s directives.

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9. *Id.* at 217, Table 10A-1.
10. *Id.* at 137, Table 8-1.
12. *Id.*
13. *Id.*
Despite their imperfections, advance directives do provide valuable assistance to physicians and other health care providers as they attempt to ascertain what care the patient would want.\textsuperscript{14} The purpose of this Article is to examine legislative enactments concerning advance directives recently adopted in West Virginia and to analyze the level of protection they afford incapacitated patients to refuse unwanted medical treatment. The Article concludes that these advance directives, although laudable and useful, are not widely utilized and that a significant gap exists in West Virginia's legislative scheme which should be closed by enactment of a family/surrogate decisionmaking statute. Such a statute would ensure that families may make medical decisions on behalf of patients who have lost decisionmaking capacity without making their medical wishes known either through a written advance directive or specific oral directive.

II. ADVANCE DIRECTIVE LEGISLATION IN WEST VIRGINIA

Few individuals actually provide their physicians with explicit instructions regarding their intent to refuse medical treatment should they lose the capacity to decide.\textsuperscript{15} Recently enacted "advance directive" legislation in West Virginia recognizes that an individual may retain his right to direct the extent of medical intervention, should he become incapacitated, by the execution of a medical power of attorney or living will.

A. The Medical Power of Attorney Act

On March 1, 1990, the West Virginia Legislature enacted the Medical Power of Attorney Act\textsuperscript{16} (MPAA) and moved West Virginia to the forefront of those states with enlightened legislative policies regarding written advance directives and proxy decisionmaking. By executing a medical power of attorney, West Virginians can, in a

\textsuperscript{14} Id.


legally effective manner, avoid becoming, as Justice Brennan described it, "passive subjects of medical technology." 17

1. Background

The medical power of attorney first emerged as a possibility in West Virginia in the summer of 1989 when the Guardianship Task Force of the Department of Health and Human Resources 18 sensed growing public support for legislation in the area of advance directives. At that time West Virginia had a living will law. 19 However, the Task Force convinced of the extremely limited utility of that statute, decided to develop proxy legislation that would permit capable adults to appoint another person to make medical decisions for them should they become unable to decide for themselves.

Before it could begin drafting a bill, however, the Task Force had to decide whether to amend the Uniform Durable Power of Attorney Act 20 or to develop a separate statute related solely to medical decisionmaking. After extensive research and discussion of the approaches adopted in other states, the Task Force decided to develop a separate statute and to include in it an over-arching statement of legislative policy regarding an individual's right to execute advance directives, including directives to terminate life-prolonging intervention. The Task Force also decided to include a statement expressing a strong legislative preference that decisions regarding medical care, including termination of life support, be followed without resort to the State's judicial system. 21

Because the Task Force believed that a proxy, or representative, provided more effective protection for persons attempting to ensure

18. The Guardianship Task Force is composed of a group of lawyers, doctors, senior citizen advocates, disability specialists, mental health specialists, and health care professionals. It has compiled an enviable track record of legislative successes in the area of patient decisionmaking. The Task Force has also been instrumental in launching a statewide educational effort regarding advance directives, including the drafting of an advance directives booklet which has been distributed to every Medicare and Medicaid provider in West Virginia.
20. Id. § 39-4-1 to 7 (Supp. 1991).
21. West Virginia does not have a judicial decision discussing a person's right to terminate life-support.
that their wishes would be honored than a living will, no attempt was made to engraft the proxy provisions onto the existing living will law.

2. Specific Provisions of the Act

In its statement of purpose and legislative findings, the MPAA recognizes an individual's reasonable expectations of dignity and privacy and common-law right to shape the extent of medical intervention in the natural dying process through the use of "advance directives," and it extends that autonomy beyond a patient's period of capacity.\(^2\) Thus, a person (the "principal"),\(^2\) while capable, may appoint a "representative" to make treatment decisions on his behalf after capacity is lost.\(^2\) Incapacity is defined as:

\[
\text{inability, because of physical or mental impairment, to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner, as determined by two physicians or by one physician and one licensed psychologist, both of whom are licensed to practice in this state, and additionally, have examined the principal. The principal's attending physician shall be one of those who makes the determination required herein.}^{23}
\]

The MPAA also permits individuals, while still capable, to express specific treatment preferences to be honored after capacity to make medical decisions has been lost.\(^2\) Even in the absence of specific directives, however, a representative's authority to act on the principal's behalf remains intact.\(^2\)

The legislative findings encourage capable adults to issue advance directives and impose a duty on health care providers to respect the

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23. In order to execute a medical power of attorney a principal must be 18 years or older. W. VA. CODE § 16-30A-2(b) (1991).
24. Id. § 16-30A-3.
25. Id.
26. Id. §§ 16-30A-4(b) and 18.
27. Id. § 16-30A-4(b). When the principal's wishes are unknown, the representative is to act in the best interests of the principal. See infra text accompanying notes 31-33 and note 35.
known wishes of patients even in the absence of written directives.\(^{28}\) Thus, it is clear in West Virginia that an oral directive of a capable patient is legally binding on health care providers, even after that patient has lost capacity.\(^{29}\) Additionally, the findings set forth the Task Force’s strongly held conviction that the courts “should not be the usual venue” for making decisions about medical treatment, including decisions about life-prolonging intervention.\(^{30}\) Thus, where a representative is appointed pursuant to the MPAA, decisions to terminate medical treatment of an incapacitated patient, including decisions to withhold or withdraw artificial hydration and nutrition, should not be subject to the precondition of judicial approval in West Virginia.

The representative is directed to act pursuant to the known desires of the principal, or in the principal’s “best interests” if his specific desires are unknown.\(^{31}\) This legislative enactment of the best interests standard was recommended by the Task Force because it believed that standard would not only ensure that a representative’s decisions are consistent with sound medical practice and ethical conduct, this standard would also reflect the patient’s interests more closely than a purely technological decision to do whatever is possible.\(^{32}\) The Task Force rejected as guesswork the legal fiction of substituted judgment that has been adopted by some state courts.\(^{33}\)

Appointment of a representative is one of the most important decisions an individual will ever make. The public educational effort undertaken by the Task Force following passage of the MPAA\(^{34}\) has underscored the importance of appointing as a representative some-

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\(^{28}\) Id. § 16-30A-2(b)(5).

\(^{29}\) Id. § 16-30A-4(b).

\(^{30}\) Id.

\(^{31}\) Id.


\(^{33}\) See, e.g., Guardianship of Jane Doe, 583 N.E.2d 1263 (Mass. 1992); In re Estate of Longeway, 549 N.E.2d 292, 299 (Ill. 1989). Contra In re Westchester County Medical Ctr. on behalf of O’Connor, 531 N.E.2d 607 (N.Y. 1988) (holding that the patient must have clearly expressed her intent before a surrogate decisionmaker could refuse treatment).

\(^{34}\) See supra note 18.
one who is known and trusted by the principal. The principal should not appoint as representative anyone who cannot be trusted to follow the directives of the principal. Careful thought about and discussion with the representative should precede the appointment. Obviously, the principal should obtain the representative's agreement to serve before making the appointment.

Unless the principal specifically provides otherwise, the powers delegated to the representative include a full range of health care decisions that frequently must be made for incapacitated patients. These can include, but do not necessarily involve, decisions to terminate life support. Under the MPAA, representatives can decide matters of health care management as ordinary as access to medical records and the power to hire and fire health care personnel.

In the absence of specific directives, representatives are empowered to decide when to terminate life support, including artificial hydration and nutrition. In drafting the bill, the Guardianship Task Force sought to ensure that the representative would have the right to decide in appropriate cases to forego artificial hydration and nutrition. Sensitive to the fact that artificial hydration and nutrition

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35. W. Va. Code §§ 16-30A-4(d)(1) to (8) (1991) enumerate certain of the powers delegated to the representative. These powers include but are not limited to:

1. Making decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care;
2. Permitting or gaining access to all medical records;
3. Acknowledging receipt of notification of rights or responsibilities and any applicable rules of medical or health care facilities;
4. Employing or discharging medical providers;
5. Making decisions about measures for the relief of pain;
6. Consenting to, refusing or withdrawing any and all medical treatment or diagnostic procedures, including but not limited to, life-prolonging intervention when in the opinion of two physicians who have examined the principal, one of whom being the principal's attending physician, such life-prolonging intervention offers no medical hope of benefit;
7. Making decisions about the gift or donation of a body organ or tissue;
8. Enforcing a declaration made pursuant to the West Virginia Natural Death Act (living will), as provided in chapter sixteen [§ 16-30-1 et seq.], article thirty of this code: Provided, that where the provisions of such a declaration and the special directives to the representative hereunder are in conflict, the provisions of the document executed later in time shall control or govern.

36. W. Va. Code § 16-30A-4(d)(6) (1991). Two physicians, one of whom is the attending physician, must have examined the patient and concluded that such life-prolonging intervention offers no medical hope of benefit.
are rocks on which advance directive legislation in other states have foundered, the Task Force avoided the use of these specific terms. Instead, it chose to employ the phrase "life-prolonging intervention", intending thereby to cover a variety of situations, including the withholding or withdrawal of artificial hydration and nutrition and ventilator support.

Although the MPAA does not define the term "life-prolonging intervention," the 1991 amendments to the Natural Death Act do, and that definition must be read in pari materia with the provisions of the MPAA. Under the Natural Death Act,

"[l]ife-prolonging intervention' means any medical procedure or intervention which, when applied to a person, would serve solely to artificially prolong the dying process or to maintain the person in a persistent vegetative state. The term . . . does not include the administration of medication or the performance of any other medical procedure deemed necessary to provide comfort or alleviate pain."  

As noted, although not specifically stated in either the MPAA or the Natural Death Act, this definition authorizes the representative to direct the withdrawal of artificial hydration and nutrition as a form of medical treatment from a patient who either is terminally ill where death will result in a relatively short time, or is in a persistent vegetative state.

A representative may direct the withdrawal of "life-prolonging intervention" only after two physicians, one of whom must be the attending physician, have examined the patient and have determined that further treatment "offers no medical hope of benefit."  

The term "medical hope of benefit" is not defined, but the absence of a definition is not a drafting oversight. The Guardianship Task Force intended, and the Legislature agreed, that the inquiry concerning whether to withhold or withdraw life-prolonging intervention should be postured as a medical one, with the decision based on the clinical prognosis of the patient, not the mere availability of technology.

In an attempt to assure that legal technicalities do not overturn a principal's appointment of a representative to make health care

decisions, the Act provides that whenever proceedings are initiated before a county commission for the appointment of a committee or guardian and the principal has executed a medical power of attorney, absent good cause for deciding otherwise, the representative is to be appointed committee for medical decisions.\textsuperscript{39} This provision should eliminate, wherever possible, the appointment of sheriffs or other governmental entities as medical decisionmakers. Additionally, to avoid guardianship proceedings which can sometimes be long-delayed and costly, a principal may use the medical power of attorney to nominate his committee or guardian.\textsuperscript{40}

The principal may and should appoint one or more successor representatives to serve in the event the original representative is unable to act.\textsuperscript{41} Of critical importance, the Act also provides that a principal’s medical directives, or statement of specific values or instructions, survive even if the medical power of attorney lapses due to the inability of the representative to serve.\textsuperscript{42}

The requirements for executing a medical power of attorney are not stringent. It must be in writing, signed by the principal or by another person in the principal’s presence at the principal’s express direction, dated, signed in front of two witnesses and acknowledged before a notary public.\textsuperscript{43} As in the Natural Death Act, certain individuals who may inherit from the principal are prohibited from serving as witnesses.\textsuperscript{44} Treating health care providers and their employees not related to the principal, or operators of a health care facility or their employees not related to the principal, are prohibited from serving as a representative.\textsuperscript{45}

The fact that employees of a health care facility, who are not otherwise prohibited, may witness a patient’s medical power of at-

\textsuperscript{39} Id. § 16-30A-4(e) (1991).
\textsuperscript{40} Id. § 16-30A-7.
\textsuperscript{41} Id. § 16-30A-5(a).
\textsuperscript{42} Id. § 16-30A-5(b). When a divorce automatically revokes the appointment of a spouse as representative, see id. § 16-30-13(d); this savings clause can preserve a principal’s specific directives if the divorced principal fails to execute a new medical power of attorney.
\textsuperscript{43} Id. § 16-30A-6(a).
\textsuperscript{44} Id. § 16-30A-6(b). See infra text accompanying notes 88-96.
\textsuperscript{45} Id. § 16-30A-6(c).
torney (or living will) even though they may not serve as representatives can cause confusion. The decision to permit health care employees to witness advance directives occurred after considerable discussion and was intended to assist patients who decide to execute an advance directive after they have been admitted to a health care facility. Attending physicians, however, are always prohibited from acting as witnesses or representatives for their patients.

Under the MPAA, a presumption exists that any principal who has executed a medical power of attorney was of sound mind at the time, and that all witnesses were qualified. Thus, any person seeking to challenge the effectiveness of an appointment or the specific directive of a representative bears the burden of proving the principal's incapacity or witnesses' disqualification. Furthermore, should it appear at a later time that the medical power of attorney had been revoked, a representative may attest that he had no knowledge of any revocation of the medical power of attorney while exercising the power. The attestation places the burden on the person challenging the representative to prove that the representative knew his actions were unauthorized.

To encourage compliance by health care providers with the directives of patients and their representatives, the Act provides immunity from civil and criminal liability to physicians, licensed health care professionals, health facilities and their employees who in good faith comply with or rely on the directions of a representative. The Task Force viewed this as a crucial provision. Aware that court decisions about the conflicting interests involved in surrogate decisionmaking abound, the Task Force feared that without immunity few health care providers would comply with a directive to terminate life support absent a court order. The statute also provides a conscience clause for providers who do not want to honor a patient's advance directive or who choose not to follow the instructions of the representative.

46. Id. § 16-30A-8.
47. Id. § 16-30A-9.
48. Id. § 16-30A-10(a).
49. Id. § 16-30A-10(b). An attending physician who "cannot or will not" comply with or act
Physicians and other health care providers must include the medical power of attorney as a part of the patient’s current medical records. This important provision requires hospitals, doctors, nursing homes, and others to inquire as to whether the patient has a medical power of attorney, or any other form of an advance directive, and place it in the patient’s chart. Under West Virginia’s developing law of informed consent, health care providers and physicians failing to comply with this provision could face potential tort liability if inappropriate treatment is rendered due to the failure to place the advance directive in the patient’s chart.

The representative has the same legal right as the principal to receive information about medical records and proposed health care. Thus, to the extent the principal could have, a representative may authorize the release of medical records — including information pertaining to AIDS, treatment for alcoholism or substance abuse, or psychiatric treatment. Obviously, the representative may also sign informed consent forms authorizing treatment.

The law requires that certain procedures be followed to revoke the medical power of attorney. The proper methods include destruction, written revocation, verbal revocation later confirmed in writing and automatic revocation as a result of a divorce. A verbal revocation must be communicated to the physician to be effective and the physician must specifically note the date, time, and place of revocation in the patient’s medical record. To avoid a lapse due to automatic revocation of a medical power of attorney because of a divorce, attorneys involved in family law cases need to advise

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in reliance upon the directions of the representative must transfer the principal to another physician who will comply with those directives. The representative is required to cooperate with the physician in effecting the transfer, and the transfer does not constitute abandonment of the patient by the physician. If the transfer is impeded or prevented because no provider will accept the patient, the attending physician or hospital would be required to maintain the status quo or seek a court order to overturn the representative's directive. See discussion of the Helga Wanglie case, supra note 5.

51. See generally Cross v. Trapp, 294 S.E.2d 446 (W. Va. 1982). Hospitals should inquire of patients upon each inpatient admission about the existence of an advance directive. Physicians should update patient records regarding the existence of advance directives at least annually.
53. Id. § 16-30A-13(a)-(d).
54. Id. § 16-30A-13(c).
clients whose former spouses were designated as representatives to execute a new medical power of attorney.

In addition to providing general civil and criminal immunities to health care providers who follow the directives of a representative, the MPAA protects both health care providers and representatives from charges of homicide, suicide, or assisting suicide for complying with any direction to withhold or withdraw treatment or refusal to consent to treatment.\textsuperscript{55} It also assures that the sale of life insurance policies may not be invalidated by the execution of the medical power of attorney.\textsuperscript{56} Nor may any payouts on a life insurance policy be impaired or invalidated by an insurance company due to the presence of a direction to withhold or withdraw life-prolonging intervention.\textsuperscript{57}

The Act grandfathers any durable power of attorney drafted pursuant to W. Va. Code § 39-4-1 \textit{et seq.} and executed prior to March 1, 1990, which expressly delegates health care decisions.\textsuperscript{58} Following passage of the MPAA, however, health care facilities, such as hospitals and nursing homes, that historically have relied on the instructions of a general power of attorney must now obtain an express delegation of medical decision-making authority.\textsuperscript{59} General durable powers of attorney thus may include the statutory medical power of attorney form.\textsuperscript{60} Further, the Act creates no presumption regarding the intention of an individual who has not executed a medical power of attorney, thereby preserving to the capable individual the right to direct health care decisions by other means.\textsuperscript{61}

The MPAA specifically prohibits "mercy killing" or "any affirmative or deliberate act or omission to end a human life other
than to permit the natural process of dying." The Act, however, does not define "the natural process of dying." Thus, as the national debate on death and dying intensifies, West Virginia courts may be asked to interpret this language and determine if any conflict exists between the statute's prohibition of euthanasia and its provision permitting a representative to direct the withholding or withdrawal of life-prolonging intervention such as artificial hydration and nutrition.

Consistent with the Natural Death Act, the statute prohibits any health care facility from denying a patient admission based on the presence or absence of a medical power of attorney. Also, anticipating a spurt of advance directive legislation in other states, the Act grants reciprocity to medical powers of attorney or health care powers of attorney executed in compliance with other state laws, and also to directives executed in other states but in compliance with West Virginia law.

The suggested statutory form of a medical power of attorney contains the following required language:

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

Although the failure to include this "springing" language arguably could void the appointment of the representative, the broad public policy of the MPAA favoring the implementation of a patient's advance directives makes it unlikely that a court would choose to do so. Any court faced with a technically deficient document should strive to give effect to its specific directives, and also to

62. Id. § 16-30A-16(a).
63. As discussed supra, in text, both the Guardianship Task Force and the Legislature intended the term "life-prolonging intervention" to include the withholding or withdrawal of artificial hydration and nutrition from appropriate patients. Thus, a decision to withhold or withdraw artificial hydration and nutrition from a patient where the conditions of the MPAA have been met should not violate § 16(a). However, the use of the "suicide machine" designed by Dr. Jack Kevorkian, the self-proclaimed euthanasia advocate, to inject lethal doses of drugs into the bloodstream of patients wanting to commit suicide is prohibited.
66. Id. § 16-30A-18.
preserve the appointment of a representative, if it can be demonstrated that the incapacitated principal executed the medical power of attorney while capable and free from undue influence. There is absolutely no purpose or finding enunciated in the Act that would be served by voiding an otherwise reliable advance directive on a technical pretext. 67

The model form provides that the principal may specify any special directives regarding treatment and any limitations on the powers granted to the representative. Unfortunately, because the form also indicates that one may write "none" in the space provided, many individuals may fail to take advantage of the opportunity to prepare specific instructions for their representatives. 68

Such instructions have considerable utility. At the least, a principal may clarify his general attitude about the use of life-prolonging medical intervention in the event of incapacity. And to the extent that the principal addresses in advance a full panoply of potential medical situations (permanent unconsciousness, fatal organ deficiency, progressive degenerative disease, senility, and organic brain syndrome), he will be able to provide valuable guidance for a representative who may be called upon at a later time to decide whether to withhold or withdraw various interventions.

The MPAA does not impose an evidentiary standard to be complied with before life-prolonging intervention may be withheld or withdrawn. The Task Force debated the issue and concluded that where a principal’s wishes are not known, the best interests standard incorporated in the statute adequately protects an incapacitated patient and assures that the representative’s decisions are consistent with sound medical practice and ethical conduct. 69

67. In fact, the model form states that if “the law does not recognize this document as legally binding and effective . . . this document [should] be taken as a formal statement of [the principal’s] desire concerning the method by which any health care decisions should be made [during any period of incapacity].” Id. § 16-30A-18.

68. See Norman L. Cantor, My Annotated Living Will, 18 LAW, MED. & HEALTH CARE 114 (1990).

69. The Task Force reasoned that because the MPAA does not require persons to seek adjudication of decisions regarding the withholding or withdrawal of life-prolonging intervention, resort to an evidentiary standard, and, particularly, the clear and convincing evidence standard favored by Missouri (which appears to reject any evidence other than a specific written directive) was inappropriate.
Although there is no basis to believe that the West Virginia Supreme Court of Appeals would engraft onto the statute the restrictive clear and convincing evidence standard required by Missouri, Cruzan's holding — that states may limit the effectiveness of a surrogate’s directive to withdraw life prolonging intervention from a patient in a persistent vegetative state by requiring “clear and convincing” evidence that the patient would not have wanted the treatment — instructs that every individual should annotate his advance directive with a discussion of general beliefs and desires as well as substantive instructions. If judicial review of a representative’s decision later occurs, whether in West Virginia or in another state with a more restrictive statutory framework, such documentation will be of critical importance in informing a court about the principal’s wishes and assuring compliance with them.

Under the Act, West Virginia provides immunity from charges of unauthorized practice of law for health care providers, physicians, social workers, social service agencies, senior citizens centers, hospitals, nursing homes, personal care homes, community care facilities, or any other similar person or group who without charge provide the medical power of attorney form to the public. The Task Force included this unique provision to underscore its conviction that legal advice, although always beneficial, was not an essential prerequisite to the execution of a medical power of attorney.

Concern about the public’s ignorance of advance directives and general reluctance to consult attorneys for fear of the cost involved caused the Task Force to advocate for a statutory scheme that would provide inexpensive access to advance directives. The Legislature wholeheartedly approved the Task Force’s goal of assuring that professionals and others who ordinarily interface with the public, particularly the elderly, may assist individuals in executing advance directives without fear of reprisal, thus the MPAA assures that individuals who might never seek legal advice are able to obtain information about advance directives from other learned professions.

71. Far from removing lawyers from the process, passage of the Act actually sparked an unprecedented cooperative effort between lawyers and physicians to inform the public about advance
B. The West Virginia Natural Death Act

The earliest advance directive statute in West Virginia was the Natural Death Act. Enacted in 1984 and modeled generally on the California Natural Death Act, the Act prescribed a format to direct what medical intervention should be withheld or withdrawn from persons who lost decisionmaking capacity and were in a terminal condition. Unlike proxy legislation, it was not intended to address a broad range of health situations.

Although its shortcomings as a health planning document were recognized, there was no effort to amend the Act’s substantive provisions until the *Cruzan* case made its way through the judicial system. As a result of *Cruzan*, natural death acts generally were criticized for failing to address the situation of a patient in a persistent vegetative state. On the impetus of the Guardianship Task Force, the West Virginia Legislature in 1991 substantially revised the Act to include the persistent vegetative state as a covered condition.

Unlike the MPAA, the Natural Death Act does contain a section of definitions and defines the persistent vegetative state as “a permanent and irreversible state as diagnosed by the attending physician and a second physician in which the person has intact brain stem function but no higher cortical function and has neither self-awareness or awareness of the surroundings in a learned manner.”

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directives. The West Virginia State Bar, working in conjunction with the Guardianship Task Force and the West Virginia Medical Association, spearheaded an effort to inform West Virginians about their right to decide what kind of medical treatment they would want when they are no longer able to direct the care themselves. An “Advance Directive Handbook” of questions and answers about living wills and medical powers of attorney was drafted and teams of physicians and lawyers blanketed the state with special programs to provide free advice and assistance. The “Handbook” also fulfills the requirement of § 19(b) of the Act that the Secretary of Health and Human Resources issue guidelines concerning the manner of execution and revocation of medical powers of attorney while a principal is a patient in a health care facility. It is available in hospitals and extended care facilities throughout West Virginia.

74. MEISEL, supra note 8, at 270.
76. Id. § 16-30-2 (Supp. 1991).
77. Id. § 16-30-2(8). This definition was drafted for the Guardianship Task Force by Alvin H. Moss, M.D., Associate Professor of Medicine and Director, Center for Health, Ethics and Law, West Virginia University School of Medicine, and a member of the Task Force.
amended Act, therefore, permits a "declarant" to execute a "living will" directing whether "life-prolonging intervention" should be used when the individual is either terminally ill or in a persistent vegetative state and no longer capable of directing health care decisions.

The Guardianship Task Force also recommended that the term "terminal condition" be amended. The original Act had defined a terminal condition to be an incurable condition, caused by injury, disease, or illness, in which, within reasonable medical judgment, the "application of life-sustaining procedures serves only to postpone the moment of death." The definition had been criticized as ambiguous in its lack of guidance to a physician about when to follow a living will's directives. Added confusion resulted from the fact that the model "Declaration" provided that life sustaining procedures could be withhold or withdrawn where they "would serve only to artificially prolong the dying process."

The amendment changed the definition of a terminal condition to one "which in the judgment of the attending physician and a second physician would result in death within a relatively short time." The phrase "within a relatively short time" was borrowed from the Uniform Rights of the Terminally Ill Act. The amendment also made explicit the inference in the original Act that a second physician must confirm the diagnosis of a terminal condition. In the original Act, that protective requirement was stated only in the model form.
The Act permits any mentally competent person eighteen years of age or older to execute a living will. Five conditions similar to those in the MPAA must be met to effectively execute a living will.87

The Act limits those who can witness the living will. One who signs the living will at the declarant's instruction cannot also serve as a witness.88 Nor may the witness be a relative of the declarant by blood or marriage,89 directly financially responsible for the declarant's medical care,90 or entitled to receive any portion of the declarant's estate.91 The Act does allow an exception if the witness did not know at the time of witnessing the living will that he or she was named in the declarant's will.92 Finally, the witness may not be the declarant's physician93 or health care representative, proxy or successor health care representative.94 The 1984 Act had precluded employees of health care facilities from serving as witnesses.95 To make the witness provisions of the Act consistent the MPAA, the 1991 amendments eliminated that prohibition and also the requirement that witnesses attest to a declarant's competency.96

Under the Act, the declarant must notify the attending physician of the existence of the living will. Upon receiving such notice, the attending physician must make the living will a part of the declarant's medical records.97

In an effort to ensure that directives in living wills are honored, the Act details the physician's role and type of documentation necessary to confirm a diagnosis of either a terminal condition or persistent vegetative state: once an attending physician makes the

87. The living will must be: "1) in writing; 2) executed by the declarant or by another person in the declarant's presence at the declarant's express direction if the declarant is physically unable to do so; 3) dated; 4) signed in the presence of two or more witnesses at least eighteen years of age; and 5) ... acknowledged before a notary public." W. Va. Code § 16-30-3(a) (Supp. 1991).
88. Id. § 16-30-3(b)(1).
89. Id. § 16-30-3(b)(2).
90. Id. § 16-30-3(b)(4).
91. Id. § 16-30-3(b)(3).
92. Id.
93. Id. § 16-30-3(b)(5).
94. Id. § 16-30-3(b)(6).
97. Id. § 16-30-3(c).
diagnosis of a terminal condition or persistent vegetative state in a patient with a living will, the physician must "without delay" have the diagnosis confirmed in writing and document the diagnosis in the patient's medical chart.98 Thereafter, the physician must inform the patient about the terminal condition. If the patient lacks capacity to understand the nature and impact of the diagnosis, the physician must notify the patient's "health care representative, next of kin or other responsible person" of the diagnosis.99 The physician must document the communication with either the patient or the patient's surrogate in the medical record.100 Finally, to assure that physicians will know that a patient has executed a living will, the statute requires health care facilities to flag the medical charts of all such patients.101

Consistent with the MPAA, the Natural Death Act contains insurance and civil and criminal immunity provisions102 and permits conscience transfers by physicians.103 The amendments "save" living wills executed prior to June 27, 1991, and grant reciprocity to those executed in compliance with the laws of other states so long as those declarations expressly provide for the withholding or withdrawal of life-prolonging intervention or the termination of life-sustaining procedures.104 Reflecting the Task Force's concern that the original statute created obstacles that hampered the public's willingness to utilize living wills, the amended Act removed felony criminal penalties for the willful tampering with or forgery of a living will.105

The 1991 amendments require that at the time of admission to any "hospital or extended care facility" every patient be advised of the existence and availability of living will and medical power of

98. Id. § 16-30-5(a).
99. Id. § 16-30-5(b). One could argue that this hierarchy creates categories of surrogate decisionmakers. See discussion of the need for a surrogate/family decisionmaking statute in West Virginia, infra text accompanying note 129.
100. Id.
101. Id. § 16-30-5(c).
102. Id. §§ 16-30-8 & -7(a).
103. Id. § 16-30-7(b).
104. Id. § 16-30-10(c) and 11.
105. See former W. VA. Code § 16-30-7(c) and (d) (1991).
attorney forms and be given assistance in completing such forms.\textsuperscript{106} This provision enlarges on the provision of the federal "Patient Self-Determination Act of 1990" (OBRA 90)\textsuperscript{107} which requires Medicare and Medicaid providers\textsuperscript{108} to make such information and assistance available. In West Virginia, all hospitals and extended care facilities, regardless of their participation in federal programs, must provide information and assistance to patients concerning advance directives.\textsuperscript{109}

The Act also forbids any hospital or extended care facility to deny admission to the facility based on the person's execution of or failure to execute a living will or medical power of attorney.\textsuperscript{110} Thus, even though hospitals and extended care facilities are obligated to provide information about advance directives, no patient can be forced to execute such a document in order to gain admission to the facility.

The Act provides a model form with directives, but makes it clear that other forms and additional directives will be honored.\textsuperscript{111} In fact, the form contains blank lines to encourage the addition of special directives "not inconsistent with other provisions of this Article."\textsuperscript{112}

If a declarant includes special directives applicable to situations other than the terminal condition or persistent vegetative state covered by the Act, the question arises whether a provider should follow such directives.\textsuperscript{113} West Virginia providers should follow any specific

\textsuperscript{108} Hospitals, skilled nursing facilities, home health agencies, hospice and prepaid organizations are covered by the programs.
\textsuperscript{111} W. Va. Code § 16-30A-3(e) (Supp. 1991). "The living Will may, but need not, be in the following form, and may include other specific directions not inconsistent with other provisions of this article."
\textsuperscript{112} Id.
\textsuperscript{113} See id. § 16-30A-2 (1991). See also Meisel, supra note 8, at 265: "Most courts that have considered the issue have held that natural death acts are not intended to pre-empt common law or state constitutional rights, to make advance directives," (citing In re Browning, 568 So. 2d 4 (Fla. 1990)).
directives of a patient without capacity, but not in a terminal condition or persistent vegetative state, where it is demonstrated that the patient was capable when the directives were issued and expressly requested that those directives be followed in situations other than a terminal condition or persistent vegetative state. It appears constitutionally suspect to limit a declarant’s ability to direct medical decisions through a living will when the MPAA permits a principal or representative to direct a broad range of health matters,114 and any capable adult in West Virginia may consent to or refuse any medical treatment.115 Thus, individuals who choose to execute a living will, in lieu of appointing a representative or providing specific oral directives, should have the same opportunity to direct their health care decisions as those who appoint a proxy or state their wishes verbally.116

III. CONCLUSION

West Virginia’s Medical Power of Attorney Act recognizes a common law tradition of medical self-determination as well as an “expectation of privacy” to refuse treatment, including life-prolonging interventions that offer no medical hope of benefit. It also establishes that treatment refusal decisions should be resolved by those who best know and understand the values and needs of the individual patient and not the judicial system.

Neither it nor its companion, The Natural Death Act, will have an impact on individual medical decisions, however, if they are not utilized by the public. Although efforts by public and professional groups such as the Guardianship Task Force, the West Virginia State Bar, and the West Virginia Medical Association to inform West Virginians about their right to execute advance directives are laud-
able, experience instructs that too few people actually execute living wills or medical powers of attorney.\(^{117}\) The problem is more than a lack of general public awareness of the statutory scheme; it is also, as one appellate court has observed, "the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements."\(^{118}\)

What legal standards should apply to medical decisions made for patients who have lost decisionmaking capacity without ever appointing a proxy or specifying treatment wishes? Some advocates point out that such decisions have traditionally been made in private by those closest to the patient — that is, the patient’s family.\(^{119}\) Others worry that there is no way of knowing what standards are being followed in such cases and argue that patient rights are better served if health care providers and family members adhere to legislatively approved procedures and guidelines, including judicial review of certain types of termination of treatment decisions.\(^{120}\)

In her concurring opinion in *Cruzan*, Justice O’Connor noted that "no national consensus has yet emerged on the best solution" on how to protect an incapacitated patient’s liberty interest in refusing medical treatment.\(^{121}\) Yet state supreme courts have generally upheld the fundamental belief that family members are best qualified to make surrogate decisions.\(^{122}\) In agreement with the family centered approach, the American Hospital Association and American Medical

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117. *Cruzan v. Director, Missouri Dep’t of Health*, 110 S. Ct. 2841, 2857 n.1 (1990) (O’Connor, J., concurring); *Id.* at 2875 n.21 (Brennan, J., dissenting).
119. "This is nothing new in substituted decisionmaking. The state is seldom called upon to be the decisionmaker." *Cruzan v. Harmon*, 760 S.W.2d 408, 428 (Mo. 1988) (Blackmar, J., dissenting). "Missouri’s regulation is an unreasonable intrusion upon traditionally private matters." *Cruzan*, 110 S. Ct. at 2882 (Stevens, J., dissenting). The American Hospital Association includes not only those related by blood or marriage, but also friends and loved ones as recognized under state law in its definition of “family.” Brief for American Hospital Association as Amicus Curiae In Support of Petitioners at 6 n.10, *Cruzan v. Director, Missouri Dep’t of Health*, 110 S. Ct. 2841 (1990).
120. *See, e.g.*, *In re Estate of Longeway*, 549 N.E.2d 292, 301 (Ill. 1989) where the court called upon state legislatures to pass legislation that would get judges out of the business of making life-sustaining decisions.
121. *Cruzan*, 110 S. Ct. at 2859 (O’Connor, J., concurring).
122. *See, e.g.*, *In re Jobes*, 529 A.2d 434, 445 (1987) ("Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient’s approach to life, but also because of their special bonds with him or her.").
Association have consistently supported allowing family members to make treatment decisions on behalf of patients lacking capacity.\textsuperscript{123}

The reality is that families, in collaboration with physicians and other health care professionals responsible for the patient’s care, currently do make medical treatment decisions for an incapable patient, including decisions to withhold or withdraw life-prolonging intervention.\textsuperscript{124} Although such decisions are “difficult and personal,”\textsuperscript{125} they are being made; generally, they are being made beyond the purview of the court system.\textsuperscript{126}

In the aftermath of \textit{Cruzan}, states need to determine whether such decisions, although reflective of “individual values, informed by medical realities,” also are being made “within a framework governed by law.”\textsuperscript{127} A majority of justices in \textit{Cruzan} looked to state legislatures — not to medical tradition or hospital policies and procedures — to provide that framework.\textsuperscript{128} Since 1990, therefore, a growing number of state legislatures have enacted surrogate decisionmaking statutes structured to place responsibility for medical decisionmaking for an incapable patient on the patient’s family.\textsuperscript{129} Although it is beyond the scope of this article to specifically discuss those statutes, West Virginia needs to follow the lead of those states which have done so and articulate a public policy on surrogate med-


126. Brief for the American Hospital Ass’n as Amicus Curiae In Support of Petitioners at 16, \textit{Cruzan} v. Director, Missouri Dep’t of Health, 110 S. Ct. 841 (1990).
128. \textit{Id.} at 2859 (O’Connor, J., concurring) and 2851 (Scalia, J., concurring).
129. MEISEL, supra note 8. West Virginia has enacted three specific surrogate decisionmaking statutes. W. VA. CODE § 16-5C-5(a) (1991) is applicable to nursing home and personal care patients who have lost capacity to make medical decisions; W. VA. CODE § 16-3C-4 (1991) permits surrogates to consent to HIV-related testing or authorize releases of test records. In 1992, the West Virginia Legislative enacted W. VA. CODE § 16-5B-8a which covers patients in a hospital connected extended care facility.\end{footnotes}
ical decisionmaking that will keep such decisions out of court. It is time to enact legislation that fosters and protects the patient’s best interests while ensuring that health care decisions, including decisions to withhold or withdraw treatment, continue to be made by the families of the patient and without the interference of judges, attorneys, or government officials.