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Advance Medical Directives in West Virginia, Part Two

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ADVANCE MEDICAL DIRECTIVES IN WEST VIRGINIA, PART TWO

GORDON H. COPLAND*

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I. INTRODUCTION

West Virginia now has two advance directives statutes: the West Virginia Natural Death Act¹ [hereinafter Natural Death Act] and the

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 1. W. VA. CODE §§ 16-30-2 to 13 (Supp. 1991).

Medical Power of Attorney Act [hereinafter MPAA].² As indicated in the accompanying Article by Irene Keeley, the West Virginia Natural Death Act enables one to give binding advance directives regarding medical treatment and the discontinuance of life support treatment, including food and hydration, in the event of a terminal illness or a persistent vegetative state.³ The MPAA is much more comprehensive and allows all non-incapacitated adults to give binding advance directives⁴ regarding their medical care, or the withdrawal of medical care, in all circumstances — not just those in which the illness is terminal or results in a persistent vegetative state. As important as these Acts are in clarifying the legal rights of patients and precluding unneeded litigation, there remains a class of cases not covered by present statutes. The statutes do not provide for those who neglect to execute an advance directive or for those who lack the capacity to do so.⁵ The latter group contains two recognizable subgroups: children and those who by reason of illness or disability lack the capacity to govern their own medical treatment.⁶

This Article will consider the desirability of legislative action to remedy the existing legal uncertainty as to the rights of incapacitated or non-competent patients who have not given, or have never been able to give, advance directives. Although this group is much smaller than the classes of persons covered by the MPAA and Natural Death Act, it is nevertheless a significant group that will always exist. Over

2. W. VA. CODE §§ 16-30A-1 to 20 (1991).

3. *Id.* § 16-30A-4(d) (1991).

4. The directives are binding to the same extent as a competent adult's. The MPAA, however, does not make binding a directive that would not be binding for a conscious, competent adult. Thus, one cannot direct or authorize one's own killing.

5. Persons under the age of 18 cannot execute a medical power of attorney. *Id.* § 16-30A-6(a). Persons without capacity also cannot execute a medical power of attorney. "Incapacity," as defined in the statute, refers to the condition of persons who cannot appreciate the natural consequences of a health care decision or the inability to communicate one's wishes to others. *Id.* § 16-30A-3.

6. This article will not explore the question of what constitutes "incapacity" as used in the MPAA and whether the word embraces a different standard from "incapacity" for other purposes of the law, such as the power to contract. Because the Legislature did not use a common-law definition, but gave a very specific statutory definition of incapacity, there is a strong inference that the statutory standard need not be the same as the common-law standard, and that an individual might lack capacity for some purposes but nevertheless have it for purposes of the MPAA.

time, one hopes that the number of competent adults who have executed advance directives will increase dramatically; however, there will always be those who neglect or do not wish to do so, as well as those who cannot.

For the groups that are not provided for by our current statutes, this Article proposes legislative action to establish a process by which decisions for the non-competent may be made without requiring resort to the courts. Such a statute would assure health care providers that they are not at risk of civil and criminal liability. The Article also considers the appropriate standards by which health care decisions should be made for the non-competent, with particular attention given to health care decisions that will end in death. The major competing values and policy arguments regarding withdrawal of care are discussed. The concluding sections of the Article propose some specific standards for inclusion in any legislation.

II. SHOULD THERE BE A SUBSTANTIVE LIMITATION ON TREATMENT THAT CONSTITUTES THE WITHDRAWAL OF LIFE SUPPORT?

At the outset, a fundamental question is whether to establish substantive limits as to what treatment can be given to, or withheld from, the incapacitated or non-competent⁷ generally, and from those suffering from a terminal illness or persistent vegetative state. The latter two conditions are often thought to require special consideration, particularly with regard to withholding procedures or treatments that, if withdrawn, will result in death.⁸ Many medical decisions

7. Incapacitated and non-competent are used interchangeably in this article. The Natural Death Act refers to "incapacity" but most reported cases and commentators refer to "non-competent" individuals.

8. There is a good deal of dispute as to whether it is proper to characterize death as "resulting" from the withdrawal of certain procedures, or from the underlying pathology. For example, some argue that, for patients dependent upon artificial means for nutrition and hydration, any death that follows the withdrawal of the support results from the underlying pathology, not the withdrawal of the support. In this view, death results from the inability to eat or drink, not from the withdrawal of the support. This position is adopted in many cases involving withdrawal of nutrition and hydration. *E.g.*, *McConnell v. Beverly Enterprises, Conn., Inc.*, 553 A.2d 596, 605 (Conn. 1989) (agreeing with "majority of jurisdictions" that removal of artificial feeding tube is not a "death producing agent" and holding that "death will be by natural causes underlying the disease"). *Accord* *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 638 (Mass. 1986). In discussing treatment that "results" in death, the author does not intend to take sides on the question of the proper characterization in areas of dispute; in this article the phrase refers to any decision not to provide treatment that is medically likely to sustain continued life.

may result in death, but those decisions that are known to result in death for an incapacitated person surely require greater scrutiny.

In general, this Article uses the phrase "withholding life support" to describe the withholding of any treatment that is necessary to prevent biological death. There can be substantial debate as to what the phrase "life support" means; for some, classifying a procedure as mere life support may signify a pre-determination that it may be withdrawn. The usage in this Article is not intended to convey such a decision, as this Article attempts to avoid decision-making by classification. "Life support" treatment, as used here, is simply any treatment that is necessary to sustain biological life in a non-brain-dead individual. Among other things, life support could include antibiotics, chemotherapy, ventilator support, and nutrition and hydration. The inclusion of nutrition and hydration in the descriptive phrase "life support" is not an effort to sidestep the question of whether nutrition and hydration must be given, but an effort to allow the question to be addressed directly.⁹

A. *Limitations on Treatment Decisions of the Competent*

Before considering any substantive limits on medical decisions for the non-competent, it is appropriate to review the limits placed on the competent and on surrogates selected by the competent.

In the case of individuals who are "terminally ill" or in a "persistent vegetative state," as those phrases are used in the Natural

9. Of course, some argue that the characterization of a procedure as a "medical" procedure, rather than a nursing procedure or mere supportive care, is a controlling characterization. Although not basing its decision on the classification, the Missouri Supreme Court in *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841 (1990), expressly held that food and water, even artificially provided, cannot be classified as a medical treatment. The United States Supreme Court disagreed with that characterization, but nevertheless found that there was no constitutional bar to the standard adopted by Missouri to govern the withdrawal of nutrition and hydration. The American Academy of Neurology also appears to believe that classification is important, and expressly held that the "artificial provision of nutrition and hydration is a . . . medical treatment . . . rather than a nursing procedure . . ." *Position of the American Academy of Neurology On Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, 39 NEUROLOGY 125, 125 (1989). This Article's position is that no compelling rationale has been given for using the classification of procedures as a basis for determining whether it is appropriate to withdraw them. Even if that is not so, analytical clarity will be promoted by directly addressing the question of whether artificially supplied food and water may be withdrawn.

Death Act, the West Virginia Legislature has already announced a policy to allow competent individuals to reject in advance any and all treatment, including nutrition and hydration, *if* they are terminally ill or in a persistent vegetative state.¹⁰ The MPAA, in contrast, sets no limits on the powers of a surrogate to reject treatment for the principal, except that life prolonging intervention can be refused only upon the finding of two physicians that the intervention “offers no hope of medical benefit.”¹¹

Although there are no West Virginia decisions concerning the rights of the competent to directly refuse treatment, the MPAA implicitly recognizes such a right. The MPAA recognizes the right of competent adults to designate a surrogate to refuse medical treatment on behalf of the principal.¹² Manifestly, any right or power which can be conferred upon a surrogate must be possessed by the principal, and there is no reason to doubt that a competent adult in West Virginia has all of the rights that can be conferred upon a surrogate under the MPAA. Furthermore, the MPAA expressly states, in its preliminary legislative findings, that there is a “duty to respect the known wishes of patients”¹³ even in the absence of a written directive, and that “[c]ommon law tradition and the medical profession in general have traditionally recognized the right of a capable adult to accept or reject medical or surgical intervention affecting one’s own medical condition.”¹⁴ The Legislature listed the protection of “a patient’s *right* to self determination”¹⁵ as the purpose of the Article. There is little room for doubt that a West Virginia court would recognize a general right¹⁶ to accept or reject medical treatment, even apart from the federal constitutional right recognized in the highly publicized decision in *Cruzan*.¹⁷

10. W. VA. CODE § 16-30-2 to 13 (Supp. 1991).

11. W. VA. CODE § 16-30A-4(d)(6) (1991). The MPAA also prohibits “mercy killing.” *Id.* § 16-30A-16(a).

12. *Id.* § 16-30A-4.

13. *Id.* § 16-30A-2(b)(5).

14. *Id.* § 16-30A-2(b)(1).

15. *Id.* § 16-30A-2(a).

16. The generalized right need not be absolute, and there may be circumstances in which it may be overridden. The only point being made here is that there is same right regardless of its scope and source (constitution or common law).

17. *Cruzan v. Director, Missouri Dep’t of Health*, 110 S. Ct. 2841, 2852-54 (1990) (holding

In a number of cases in other jurisdictions, courts have confronted the requests of competent, non-terminally ill patients to remove or discontinue life supporting equipment or treatment. In recent cases, the courts have generally recognized the right of a competent adult to refuse life sustaining treatment.¹⁸ For example, in *McKay v. Bergstedt*¹⁹ a severely handicapped young man sought and received permission from the court to obtain a disconnection of the ventilator apparatus on which he depended for survival. The patient was severely handicapped, incapable of any motion, and had spent his entire life supported and cared for by his loving parents. The patient's mother had died some years prior to his request for termination of the ventilator, and the patient's father had become terminally ill. It was the prospect of his father's death that prompted the patient's requests for termination.

Refusal of ventilator support is not the only life support competent adults have been allowed to reject. The courts have also grappled with the question of withdrawal of food and water for the competent. A California Court of Appeals Court has upheld the right of a competent person to require removal of the tube through which she was fed.²⁰ In contrast are cases in which the state has forced individuals to accept food and water, despite their desires to the contrary. For example, prisoners have been required to accept food and water, despite their stated wish to refuse both.²¹ There are, however, no reported cases outside the area of prisons in which competent adults have been required to accept unwanted food and water.

The courts rather universally recognize the general right of a competent adult to refuse treatment, including food and water. The only limitation appears to be that competent adults have no "right"

that the liberty interest in refusing unwanted medical treatment did not invalidate Missouri law requiring clear and convincing proof of intent before court could authorize withdrawal of nutrition and hydration to patient in persistent vegetative state).

18. A summary of the cases involving competent and non-competent patients appears in ALAN MEISEL, *THE RIGHT TO DIE*, § 5 (1989) and § 10 (Supp. 1992).

19. 801 P.2d 617, 623 (Nev. 1990) (Springer, J., dissenting).

20. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

21. *Dept. of Public Welfare v. Kallinger*, 580 A.2d 887 (Pa. Commw. Ct. 1990).

to commit suicide. The criticism of decisions such as *McKay* and *Bouvia* is based on the assertion that the acts amounted to suicide.²² The handicapped plaintiffs needed assistance in removing the ventilator and withdrawing the feeding tube; if the acts were suicidal, there was no right to receive intervention. Acting on this principle, the California Court of Appeals has recently refused an injunction sought by Thomas Donaldson, who sought to receive assistance in obtaining "premortem cryogenic suspension."²³ Donaldson, who suffered from a terminal brain cancer, sought medical assistance in the freezing of his body, in the hope that future medical advances would one day allow his body to be thawed, re-animated, and healed. Donaldson sought a declaratory judgment that medical assistance would not be deemed criminal and an injunction to prevent an autopsy of his body. The court denied relief, holding that there was no right to suicide or assisted suicide.²⁴

B. Considerations Pertinent to the Non-Competent Who Have Not Expressed Their Wishes: The Special Cases Of Terminal Illness And The Persistent Vegetative State

As the preceding section makes clear, there is no basis in general law relating to treatment of the competent that would justify setting a substantive limit on the choices open to the non-competent, other than the prohibition on suicide or the absence of a right to commit suicide. The next analytic question is whether there is a basis for applying a different or more restrictive rule to decisionmaking about the non-competent.

Once one has concluded that competent individuals have the right to refuse treatment, including food and water, it follows that a designated representative should generally be allowed to exercise that right where the patient's wishes on the subject are known. There are, of course, a number of questions to be considered as to the specificity of the patient's directions and the degree of certainty by

22. *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

23. *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59 (Cal. Ct. App. 1992).

24. *Id.*

which the patient's desires must be shown, but there is little basis for disputing, in the abstract, whether competent individuals can exercise that right through a representative. The precise circumstances under which the authority can be exercised, and the procedural safeguards required, are the focus of the MPAA.

A more difficult question arises when the patient has no advance directive, and no stated wishes on treatment; the family and physicians of such a patient must determine whether to continue or to initiate life sustaining treatment in the absence of any knowledge as to the patient's desires. Although it will not be possible to provide a legislatively determined outcome for all possible medical situations, there are recurring circumstances as to which it is appropriate to consider whether the state should enact substantive limitations. The two most often-proposed classes in which to limit or enlarge the powers of a surrogate are 1) patients who are terminally ill, and 2) patients in a persistent vegetative state. A consideration of those terms is required before any determination as to standards is made.

1. Definition of "Persistent Vegetative State"

A large portion of the cases litigating life support issues relate to patients in a persistent vegetative state (PVS). The diagnosis of PVS is often colloquially referred to as a diagnosis of "irreversible coma." No diagnosis of irreversibility can be made with absolute certainty, but the diagnosis of PVS reflects a medical judgment that a return to consciousness is beyond medical hope.²⁵ Patients in a persistent vegetative state are not brain dead; they experience sleep and wake cycles, and may open their eyes. They are not, however, responsive to their environment and show no cognitive abilities. Persons properly diagnosed as being in a persistent vegetative state have

25. Under the Natural Death Act, PVS is defined as a "permanent and irreversible state 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." W. VA. CODE § 16-30-2(8) (Supp. 1991). Although the statute refers to "irreversibility," absolute medical certainty on this point is not possible, as illustrated by the Carrie Coons case, *infra* note 45. The statute requires a diagnosis of irreversibility, but does not require absolute certainty in the diagnosis.

no cognition and do not experience either pain or pleasure.²⁶

A diagnosis of PVS does not necessarily indicate terminal illness; patients so diagnosed often have an indefinite life expectancy, although their life expectancies are probably shortened by their necessary institutionalization and attendant medical procedures. Patients in a persistent vegetative state cannot ingest food or water. They are therefore universally dependent on artificial nutrition and hydration. They are not, however, necessarily dependent on a mechanical ventilator or artificial respiration.

2. Definition of "Terminally Ill"

It might appear that there is little need to consider the meaning of "terminally ill," but some definitional problems exist. In common usage, a terminal illness is one that will result in death in a relatively short time, regardless of any medical treatment that may be given. The Natural Death Act tracks ordinary usage and defines "terminal condition" as "an incurable condition . . . which . . . would result in death within a relatively short time."²⁷ The statute does not require that death be inevitable regardless of whether treatment is given, although that is the probable intent of requiring that a condition be "incurable." Conceivably, one could have an incurable condition in which proper treatment would postpone death for a long period.

This point can have significance, because certain states define terminal illnesses to include illnesses which will result in death only if no treatment is given. Montana appears to use that definition: the Montana Rights of the Terminally Ill Act defines a terminal condition as one that will result in death absent the administration of treatment.²⁸ Patients in a persistent vegetative state are, by this

26. The description of PVS in this and the subsequent paragraph is taken from the American Academy of Neurology's position statement on PVS: *Position of the American Academy of Neurology On Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, 39 NEUROLOGY 125 (1989). A diagnosis of PVS differs from the so-called "locked-in" state, in which a patient may have awareness of his environment (and may have use of his senses). In a locked-in state, however, the patient is incapable of expressing or responding to any outside stimulus, although the patient is aware of them.

27. W. VA. CODE § 16-30-2(10) (Supp. 1991).

28. MONT. CODE ANN. § 50-9-102(14) (1991).

definition, always terminally ill, since they will die absent medical provisions for nourishment and water.

In order to promote analytic clarity, this article will use "terminal illness" to refer to conditions that will produce death in a relatively short time, regardless of the treatment that is instituted. There is a clear distinction between PVS patients and patients with incurable cancers. If this distinction is without any moral or policy difference, that should be shown by argument, rather than asserted by classification.

The Legislature should face the question of whether the representatives of competent persons, who have not expressed their desires in regard to their treatment, should be maintained on ordinary food, water, and basic medical care. Are there circumstances in which life supporting treatment clearly should or should not be withdrawn, and if so, are these special rules applicable to those suffering from a PVS or a terminal illness? The question is not whether society can or should make a decision for such persons; decisions as to medical treatment, nutrition, and hydration *will be made* for the non-competent. The question is whether that decision-making will occur haphazardly and by default, or pursuant to a well-planned legislative scheme.

C. Refusal Of Life Sustaining Procedures For Those Not In A Persistent Vegetative State Or Terminally Ill

The power to withdraw or refuse basic life sustaining treatment raises serious questions, and the exercise of this power may perhaps be improper as to many non-competent patients. There is some evidence of a social consensus, however, that it is permissible for the special cases noted above. The Natural Death Act, for example, authorizes withdrawal of life support only for those who are terminally ill or in a persistent vegetative state. The MPAA removes this limitation for competent persons who select their own surrogates, although even for patient-selected representatives, mercy killing is prohibited, and withdrawal of life support is permitted only if the continuance would offer "no hope of medical benefit." Should a more stringent standard apply to surrogates not selected by patients? Even apart from the basic question of whether it is ever right

to refuse life support, there are sound reasons to limit the withdrawal of life support to persons who are terminally ill or in a persistent vegetative state.

Many argue that there is a presumption in favor of life, and that even a patient-selected representative ought to be limited in the ability to direct withdrawal of nutrition and hydration. New York's statute corresponding to the MPAA, for example, reflects this presumption. The statute prohibits withdrawal of food and water for patients whose desires on that point cannot be determined.²⁹ Should the presumption in favor of life, or the duty to treat all persons equally, preclude withdrawal of nutrition and hydration from the severely disabled—those suffering profound reductions in their cognitive abilities, but who are not in a PVS? There are those who argue that persons who are minimally aware of their environment, but unable to feed themselves or interact “meaningfully”, should not have life support provided to them. Should there be a presumption that such persons or other disabled persons, as a class, should have their lives preserved or ended, or should the law allow for varying and conflicting results?

A statutory presumption in favor of life, and a prohibition against withdrawal of basic care, should apply to all conscious disabled patients, that is, those not in a persistent vegetative state. At a minimum, any contrary position must confront the fact that allowing scope for “individual” decisions would inevitably result in competent persons placing a value on the life of the disabled. A wide variation of capacity lies between full functioning and the persistent vegetative state. A given degree of ability will be perceived by individuals differently, and varying values assigned to the worth of a life under such circumstances. If medical decision-making for the conscious but severely disabled is not to become an assessment of the worth of such persons, then a bright line must be drawn on prohibiting the withdrawal of basic care. Such a line still allows a surrogate to reject even possibly life saving treatment, upon an appropriate showing, provided that basic care, such as nutrition and hydration, is not withdrawn.

29. N.Y. PUB. HEALTH LAW § 2982(2)(b) (McKinney Supp. 1992).

III. THE STANDARD BY WHICH DECISIONS SHOULD BE MADE FOR NON-COMPETENT PERSONS LACKING WRITTEN ADVANCE DIRECTIVES

A. *The Standard For Those Whose Wishes Can Be Ascertained*

Persons who become non-competent, and have no advance directives, such as a living will or medical power of attorney, can be divided into two categories: (1) those who have expressed some desires or directions regarding their future treatment; and (2) those who have not expressed any desires or intentions with regard to their treatment in such circumstances. There are significant policy reasons to treat the two groups differently.

As discussed above, the MPAA reflects a common-law rule that persons are entitled to control their own treatment. The MPAA and Natural Death Act were both enacted in order to assist individuals in directing their own future treatment. In both statutes, the Legislature provided that the failure to create an advance directive would not create any presumption with regard to the individual's intent regarding life support,³⁰ and the MPAA recognizes that an individual's expressed intentions regarding future treatment ought to be given effect, even absent an advance directive. For persons as to whom there are discoverable expressions of intent, the law ought to require an examination and investigation into the desires and preferences of the individual. Where that desire can be ascertained, the statute should cause it to be carried out. The central policy question in such cases is what standard of proof ought to be required and what degree of specificity ought to be known about the patient's wishes before carrying out the patient's supposed desire to have life support withdrawn.

The Supreme Court's decision in *Cruzan* has established that the federal constitution does not prohibit states from adopting a "clear and convincing" standard of evidence before allowing a comatose patient's life support to be withdrawn.³¹ At the time of the *Cruzan*

30. W. VA. CODE § 16-30A-15(c) (1991); W. VA. CODE § 16-30-9(b) (Supp. 1991).

31. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2855 (1990).

decision, New York, Missouri, Maine, and Ohio required clear and convincing proof before allowing the discontinuance of life support.³² Other states have not required clear and convincing evidence.³³

The primary basis for requiring clear and convincing evidence before permitting the discontinuance of life support is the opinion that life is inherently valuable. The chief criticism of the standard is that it requires a level of proof hardly ever likely to exist. This is particularly true if the clear and convincing evidence of intent must relate to the specific procedure and circumstances at issue. In its decision in *Cruzan*,³⁴ the Missouri Supreme Court required proof of the patient's prior direction and understanding of the specific treatment proposed, as well as its benefits and burdens.³⁵ The court even went so far as to hold that fully informed consent to future treatment under hypothetical circumstances is "definitionally impossible."³⁶ Because the evidence showed only that Nancy Cruzan had a generalized objection to life support by machine, the court held that there was no clear and convincing evidence she would reject tubal feeding.

A distinctly different reading was given to the requirement of clear and convincing evidence by the Maine Supreme Court in *In re Gardner*³⁷. In *Gardner*, the patient at issue had visited other individuals kept alive by mechanical devices and stated to his friends and family that he would not wish to be kept alive in such circum-

32. The cases cited by the Supreme Court in support of its statement are: *In re Estate of Longeway*, 549 N.E.2d 292, 300 (Ill. 1989); *McConnell v. Beverly Enterprises, Conn.*, 553 A.2d 596, 604-05 (Conn. 1989); *In re Westchester County Medical Center ex rel. O'Connor*, 531 N.E.2d 607, 613 (N.Y. 1988); *In re Gardner*, 534 A.2d 947, 952-53 (Me. 1987); *In re Jobes*, 529 A.2d 434, 443 (N.J. 1987); *Leach v. Akron General Medical Ctr.*, 426 N.E.2d 809, 815 (Ohio Ct. C.P. Summit County 1980). *Cruzan*, 110 S. Ct. at 2855. New York appears to have abrogated the O'Connor decision by statute. New York's statutory correlative to the MPAA prohibits withdrawal of food and water when the patient's desires are not known and cannot reasonably be determined. N.Y. PUB. HEALTH LAW § 2982(2)(b) (McKinney Supp. 1992).

33. See, e.g., *In re Peter*, 529 A.2d 419 (N.J. 1987).

34. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841 (1990).

35. *Id.* at 417.

36. *Id.*

37. 534 A.2d 947 (Me. 1987).

stances. The patient apparently had never expressed any specific wish regarding feeding tubes, yet the court found that there was clear and convincing evidence that the patient would wish to have the feeding tube withdrawn and stated that “[a] different result is not warranted simply because the life-sustaining procedure at issue involves the artificial provision of nutrition and hydration.”³⁸

As is apparent from *Gardner* and *Cruzan*, adopting a standard of review involves more than the election of one standard formula or another; an apparently identical standard meant very different things to the Missouri and Maine supreme courts. In adopting any standard of review, the Legislature should give careful thought to the question of the specificity of intent that must be shown. The mere adoption of a phrase, such as “clear and convincing,” invites confusion and the possibility of a result directly at odds with what the Legislature intended.

B. Possible Standard For Patients Whose Wishes Are Unknown: Best Interests And Substituted Consent

There are a number of situations in which the patient’s wishes with regard to life support will not be ascertainable. Persons who are severely handicapped from birth or early childhood, for example, will never have an opportunity to express a view on the subject.

The courts have used two different standards in considering whether to approve or disapprove decisions regarding life support for such persons. The shorthand phrases for the two standards are “best interests” and “substituted judgment”. Each standard has some appealing features.

1. The Substituted Judgment Standard

The “substituted judgment” standard requires that the decision on withdrawal of life support be made in accordance with what the patient would have decided, were he or she competent. Under the “substituted judgment” standard, the decision-maker attempts to stand in the shoes of the patient and decide the matter in the same

38. *Id.* at 954.

way the patient would, were he or she somehow made competent and aware of all the circumstances, including the fact of the patient's actual state of incompetence.³⁹ The facial appeal of the "substituted judgment" standard is that no one would wish to treat a patient in a way the patient would not wish to be treated. Nevertheless, for the narrow class of cases being considered here, the never-competent or the non-competent whose desires are unknown, it appears that the "substituted judgment" standard is meaningless.

Where the desires of a person cannot be determined, any effort to act as a non-competent person would act is hopeless. One may be able to assess what most people would desire, but one can never know what the individual would have wished. For those who have never had capacity, it is not even possible to know what "most" would want. The most recent case applying the substituted judgment standard confessed that it is a mere "legal fiction."⁴⁰ In that case, *Guardianship of Jane Doe*,⁴¹ the court's rationale for using the "legal fiction" was unpersuasive.⁴²

In *Jane Doe*, the court summarized its rationale for adopting the standard as follows:

39. The most succinct and, perhaps, most quoted statement of the standard appears in *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1949). There the court said: "the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person." *Id.* at 431.

40. *Guardianship of Jane Doe*, 583 N.E.2d 1263 (Mass. 1992).

41. *Id.*

42. There has been substantial scholarly criticism of the substituted judgment standard when applied to the non-competent whose wishes are not known. *See, e.g.*, Allen E. Buchanon, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386 (1981); Louise Harmon, *Falling Off The Vine: Legal Fictions and The Doctrine of Substituted Judgment*, 100 YALE L.J. 1 (1990); Edward D. Robertson, Jr., *Is "Substituted Judgment" a Valid Legal Concept?*, 5 ISSUES L. MED. 197 (1989); Walter M. Weber, *Substituted Judgment Doctrine: A Critical Analysis*, 1 ISSUES L. MED. 131 (1985); Steven M. Richard, Note, *Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference*, 64 NOTRE DAME L. REV. 394 (1989). Judge Liacos, author of the *Saikewicz* decision, has defended the concept in Paul J. Liacos, *Is "Substituted Judgment" a Valid Legal Concept?*, 5 ISSUES L. MED. 215 (1989). Judge Liacos's defense does not meet the objections set out in the text. Judge Liacos argues that using a "best interests" standard is improper because it "ignores" the wishes of the incompetent and thereby violates them. This defense does not meet the objection that the substituted judgment standard cannot be used when the patient's wishes are unknown, and that *any* choice made for the incompetent may violate their wishes.

We recognize that in situations in which there is an attempt to use substituted judgment for a never-competent person, it is a legal fiction. It is the legal mechanism by which society (at least in Massachusetts) attempts to vindicate liberty interests, albeit through a legal fiction. We are also aware that therefore "the substituted judgment [doctrine] is . . . difficult to apply."⁴³

After conceding that the substituted judgment standard was a fiction, the court, somewhat inconsistently, then argued that "the effort to bring the substituted judgment into step with the values and desires of the affected individual must not, and need not, be abandoned."⁴⁴ The latter argument constitutes an attempt to resurrect the argument initially abandoned: the claim that it is possible to know what an individual would want when the individual had never expressed any opinion on the subject.

Although it is not possible to know what a particular non-competent individual would want, it is possible to attempt to determine objectively what most *competent* individuals would want in similar circumstances. The *Jane Doe* majority may have been confusing this possibility with the possibility of knowing the specific desires of a particular individual. Although such an attempt is problematic for competent adults, given the wide variety of religious and ethical views of the populace,⁴⁵ it is utterly invalid when applied to the never-competent. Furthermore, a reliance on what the majority of people would want contradicts the justification for the substituted judgment standard, the personal autonomy of the *individual*. It is this autonomy that the court sought to protect in attempting to "vindicate" the liberty interests of Jane Doe.

The *Jane Doe* court's rationale nevertheless fails to show that withdrawing life support will "vindicate" the liberty interests of the patient. When the individual patient's desires are not known, the

43. 583 N.E.2d at 1268 (quoting *Guardianship of Roe*, 421 N.E.2d 40, 57 n.16 (Mass. 1981).

44. *Id.* at 518-19 (quoting *Saikewicz* 370 N.E.2d at 430-31).

45. Also pertinent are cases such as that of Carrie Coons, a person diagnosed as being in a persistent vegetative state and whose representative obtained a court order to withdraw life support. After permission to withdraw life support was granted by a New York court, Carrie Coons unexpectedly woke up from the coma. She was questioned about whether she wished to have life support withdrawn, should she again enter a coma. She stated "that's a very difficult decision to make" but gave no directions before lapsing into unconsciousness. See Sam H. Verhovek, *Right-to-Die Order Revoked as Patient in Coma Wakes*, N.Y. TIMES, April 13, 1989, at B3.

patient's very incapacity has made it impossible for anyone to vindicate the patient's liberty interests. Arguing that failing to remove such a patient from life support violates the patient's liberty interests is analogous to arguing that failure to take such an individual to church on Sundays violates the patient's right to free exercise of religion. Undoubtedly, some non-competent patients, were they competent, would utilize their free exercise rights to go to a church; some would go to synagogues or other houses of worship, and other patients to no religious services at all. In failing to take all patients to the religious service "most" would elect to attend, no "violation" of the patient's free exercise rights has occurred. The patient is incapable of exercising his or her free exercise rights, and the failure to "comply" with the patient's unknown desires works no deprivation of the right.

The *Jane Doe* "vindication" rationale has the further weakness that, if it is coherent in any sense, then it can be used equally well to support the opposite conclusion. The court's theory that a liberty interest is vindicated by *discontinuing* life support gives equal support to the opposite argument: that a liberty interest is vindicated by *continuing* life support. Non-competent individuals have the right to seek and obtain life supporting treatment. Withholding a desired treatment would be as much a violation of the liberty to seek treatment as continuing to provide it would be a violation of the liberty to reject it. In other words, if one can speak of violating the right to choose for those whose choices are unknown, then making any choice violates those rights. The violation is not cured by making the same choice for the entire group, nor by randomly making one choice or the other for each member of the group. Acting on the basis of substituted consent is, at best, random, when the wishes of the non-competent are not known. If every choice will violate a liberty interest, then a choice in favor of life seems eminently warranted.

It is probable that the "substituted judgment" standard is based on an implicit belief in one or both of the following: 1) a large part of all non-competent individuals would chose discontinuance of life support if they were able; or 2) discontinuance of support is the objectively correct decision, regardless of what the hypothetical "competent non-competent individual" would select.

If the Legislature agrees with these assumptions, it should consider stating clearly its belief in that regard, and setting a standard that reflects those beliefs. Rather than relying on the fiction of substituted judgment, the Legislature should enact a presumption that non-competent individuals in a permanent vegetative state should have life support withdrawn, based on the Legislature's finding that such individuals would generally choose it. It is probable that any open assertion of such a presumption would meet considerable resistance. This may be why the courts have chosen to ignore the question, by acting as if decisions could be made on an "individual" basis. The decisions cannot be made on an individual basis where nothing is known about the individual's preferences.⁴⁶ There is, however, no basis in policy for deliberately enacting a standard that is logically incoherent. The Legislature should not follow the rationale of courts using the "substituted judgment" standard, even if the Legislature wants to reach the same results.

C. Application of the Best Interest Standard

In the general law of care for the non-competent, in both financial and medical matters, the courts have traditionally sought to protect the non-competent from mistreatment and to serve their "best interests." If, as shown above, the substituted judgment standard is not logically coherent, then there is no reason to depart from the general standard applicable to the non-competent. In many cases, the "best interests" and "substituted judgment" standards will result in similar decisions. In a sense, the "substituted judgment" standard might always lead to an application of the "best interests" standard. In attempting to divine what another person might choose for oneself, in most cases one is entitled to presume that the person would choose whatever was in his or her best interests.

Two facts have created a problem with that assumption in cases involving medical treatment. First, one's "best interests" become

46. Decisions are, of course, based on an individual determination that the patient is in a persistent vegetative state, and has no medical hope of returning from that state. There can, however, be nothing individual about the analysis of what a patient "would" choose, if one has already determined that one does not know what the individual wants.

clouded in light of today's modern technological developments. In one sense it might be assumed that the preservation of life will always be in one's best interest, but the burdensomeness of medical treatments and the power to sustain life in the vegetative state throw that assumption into question. Second, many competent persons will base their treatment decisions not on their own best interests, but on the interests of their family members and loved ones. A mother's decision to forego chemotherapy may often be more motivated by her concern for the suffering of the family members than for herself. Similarly, many persons undoubtedly reject future medical treatment and artificial food and hydration based on their concern for the loved ones who would suffer from watching them live in an incapacitated condition. Altruism, not concern for one's best interests, often governs such decisions.

The "best interests" standard rejects a decision based on the imputed altruism of the non-competent. To the extent that any speculation as to the desires of the non-competent makes sense, applying the "best interests" standard will undoubtedly result in actions at variance with what some non-competent person "would" want. Nevertheless, acting against an individual's best interest on the basis of imputed altruism, and thereby considering the interest of others, opens the door to a host of abuses. It took society a number of years to move away from Justice Holmes' infamous dictum that "three generations of imbeciles are enough."⁴⁷ Few today would argue that it is proper to subject the non-competent to forced sterilization or other medical procedures that are not in the interests of the patient simply to avoid a burden on society or other persons. Where the decision at issue involved choosing death, not merely sterilization, for the benefit of others, the imputation of altruism is especially questionable.

Application of the best interests standards should therefore focus only on the interests of the patient. Proponents of the standard should recognize, however, that the standard is by no means as clear and easy to apply as might first appear. The difficulty is readily

47. *Buck v. Bell*, 274 U.S. 200, 207 (1927) (authorizing sterilization of mentally handicapped woman).

apparent in attempting to determine whether a decision to withdraw life support from a patient in a PVS is in the patient's best interests. It is not possible to avoid the fundamental question of values by asking whether such treatment will be "medically beneficial" to the patient and following that recommendation. In most cases, it is neither possible nor proper to attempt to impose the ultimate decision on the physicians. Generally, the treatment at issue is ventilator support or food and hydration, and the medical results of providing the treatment are usually clear; the patient will be kept alive by the treatment, but will not improve and will never be cured. Although in such circumstances many physicians would opine as to whether or not it would be "medically" beneficial to provide the treatment, the question is not at all medical. The medical results of the treatment are known and the only open question is a profoundly moral and ethical one: how to value treatment that will provide such an existence. In the difficult case of those in a persistent vegetative state, treatment will always provide a "benefit" in the narrow sense of continued life. The true locus of dispute is whether life itself is "beneficial" in such a condition.

Undoubtedly, there are many on both sides of the issue who believe that the Legislature should preclude an option in one direction or the other, either to require withdrawal of food, water, and other basic services or to prohibit it. A vigorous public debate on the propriety of those positions is called for. If the Legislature determines that it is not possible to enact a general rule for application to these recurring but excruciating cases, then it would be possible to simply repose this choice in the surrogate. Unless the Legislature wishes the courts to impose their own rule upon review of the surrogate's choices, the Legislature will have to provide that the choice of the surrogate in this matter is not subject to reversal except upon a showing of abuse of discretion or clear error. If the Legislature decides that there can be no consistent public policy on these questions, because of the difficulty and intensity of the moral beliefs on each side, then it is scarcely right to permit a back door judicial imposition of one set of values over the other.

D. Distinctions Between Initiating And Withdrawing Treatment

There appears to be, in practice, a substantial distinction in the public mind as to the legal consequences of withdrawing treatment,

and deciding not to institute treatment. There are numerous cases discussing the withdrawal of life support, including food and hydration. There is a dearth of cases discussing the legality of deciding not to *initiate* life supporting treatment.⁴⁸ There are only two or three cases litigating whether to initiate ventilator support or artificial feeding and hydration for patients in a persistent vegetative state. In general, the litigated cases concerning the initiation of treatment involve treatment that will not merely provide life support, but will also provide the possibility of a substantial improvement in health.⁴⁹

The relative absence of litigation over whether to institute life support treatment for persons in a persistent vegetative state can mean only one of two things: (1) life support treatment is nearly always initiated for non-competent persons, or (2) health care providers feel there is much less risk in failing to initiate treatment than in withdrawing it. Given the prevalence of "do not resuscitate" orders, it is obvious that health care providers do not, in every case, initiate life sustaining treatment when it is possible to do so.

Upon initial examination, there appears to be no reason to draw a distinction between the decision to initiate treatment and the decision to withdraw it. Given the same medical facts and same relative certainty of diagnosis for any given patient, the same values and risks should apply to a decision to institute treatment as to a decision to withdraw it. There is, however, one medical distinction that will generally exist between the decision to withdraw treatment and the decision not to institute it. Generally, in deciding whether or not to institute treatment, one has less medical certainty as to the likely outcome. Therefore, there ought to be some bias in favor of ini-

48. For a rare exception, see *In re Riddlemoser*, 564 A.2d 812 (Md. 1989), in which the guardians of a non-competent patient sought permission to direct the withholding of cardio-pulmonary resuscitation in the event of a cardiac arrest. More common are cases involving life saving treatment, such as blood transfusion cases involving Jehovah's Witnesses. For religious reasons, Jehovah's Witnesses do not accept blood transfusion or blood products in any medical treatment. In a number of instances, medical professionals have gone to court to obtain permission to give such treatment to children or other non-competents.

49. Thus, for example, in *In re Long Island Jewish-Hillside Medical Ctr.*, 342 N.Y.S.2d 356 (N.Y. Sup. Ct. 1973), a hospital sought and received permission to perform an amputation of a patient's gangrenous foot. The patient's doctor informed the court that the patient had a good chance of recovery if the operation was performed.

tiating treatment, in order to give a patient every chance at recovery (full or partial).

This goal will be, to some extent, defeated by physicians and families who know that the decision to institute treatment constitutes a crossing of the Rubicon. Families and physicians may fear to start a treatment that cannot be stopped, since the treatment may prove useless and may subject themselves and the patient to a uselessly prolonged dying process. The fear of protracted or emotionally painful legal proceedings will have a similar effect; even if the family knows the treatment may be stopped by such a legal proceeding, they may be reluctant to authorize treatment that can be stopped only by such a process.

There is, therefore, good reason to make the process by which a decision to end treatment the same process by which treatment is initiated. That conclusion, however, does not mean that the present procedures by which such decisions are made are necessarily correct. The only warranted conclusion is that a unified standard should govern both the decision to withdraw treatment and the decision not to initiate it.

E. Proposed Standards For Any Statutory Enactment

It is only a matter of time before West Virginia courts are confronted with questions on the treatment or withdrawal of treatment for non-competent persons who have no advance directive. Although there is little doubt that, where the wishes of the non-competent patient can be ascertained, the West Virginia courts would give effect to those wishes, the matter should be spelled out by statute, so that there need be no litigation on that point.

After specifying that the wishes of the patient control, when ascertainable, the statute must specify how to select a surrogate to determine those wishes. Health care providers should not themselves be the persons who determine the wishes of a non-competent patient. Health care providers can, of course, state what they may have heard from a patient in competent moments, but they should not be allowed to decide for the patient. Quite apart from the possibility for improper motives governing in such an arrangement, there is no

justification for imposing that added burden on health care providers. Ascertaining what a given patient would want is, in most cases, far more appropriately entrusted to family members or those who know that patient well.

At present, there are no formal procedures that govern who it is that gives medical direction to physicians for the non-competent. By custom, parents do so for their minor children and spouses for their incapacitated partners. Where the treatment at issue does not involve the withdrawal of life sustaining treatment or support, there is probably no need for a statutory ratification. In cases where there is a deliberate decision to institute "do not resuscitate" orders and orders refusing or withdrawing nutrition and hydration, it is preferable for the statute to specify an order of priority. Such a rule would protect both patients and health care providers, and would provide certainty in cases in which family members are divided.

There should be no requirement that formal "appointment" take place, but health care providers should be assured that they can rely on the direction of particular classes of person in instituting decisions not to provide life support or to withdraw it. The most usual order of priority for substituted decision makers is: 1) spouse; 2) adult children; and 3) parents.⁵⁰ The author proposes that the Legislature require unanimous consent within each "class" of representatives. For example, in the case of a patient with no spouse, but with competent children, health care professionals should be authorized to withdraw life support treatment based on agreement among all the competent children, without looking to the next class.

There are reasonable arguments to be made that a majority within a given class ought to be able to make such decisions. One argument is that the unanimity rule allows one obstructive family member to deliberately frustrate the overwhelming choice of those closest to the patient. Against this, there can be set the natural tendency of members of a group to acquiesce and the importance of and irrevocability

50. This is the order, for example, in West Virginia's statute governing substituted consent for patients in nursing and personal care homes. W. VA. CODE § 16-5C-5A(B) (1991). It is also the order set out in the Uniform Law Commissioners' Model Health-Care Consent Act. 9 U.L.A. Model Health-Care Consent Act § 4(a) (1988).

of the decision at issue. A choice that results in death for another is the most serious that one can make. Requiring unanimity on such a question hardly appears excessive, especially given the natural tendency of family members to avoid controversy.

In the event of disagreement among class members, there are three reasonable possibilities for resolving the treatment dilemma. The Legislature could provide for: 1) automatic judicial review, 2) automatic institutional review, or 3) permit the "majority" decision to be followed after a waiting period sufficient to allow the institution of legal proceedings. The fourth possibility — prohibiting withdrawal absent an agreement — should be rejected because it would allow one recalcitrant person to block implementation of a patient's desires or patient's best interests. Any standard must, at a minimum, allow the minority some opportunity to show that the majority is clearly wrong, or improperly motivated.

Determining which of the three remaining procedures to require will necessitate an assessment of the need to protect life as against the disadvantages of judicial or even institutional review proceedings in such intensely personal and painful moments. Some have suggested that institutionally-based ethics review committees should constitute a kind of arbiter, whose decision would be given effect in the event of disputes, absent some legal action by dissenting family members within a specified period of time.

In regard to substantive limitations, the Legislature should consider a prohibition on the withdrawal of artificial food and hydration from patients who are not terminally ill and not reliably diagnosed to be in a persistent vegetative state. There is a degree of arbitrariness to this limitation, which is motivated by two concerns: the prevention of any abuse and the preclusion of any inference that the non-competent have no value and may be abandoned. The provision of a means to authorize the withdrawal of life-support is based on the need to affirm the rights and dignity of individuals; that mechanism must not become instead a signal of indifference to the incapacitated. There is a fundamental emotional significance to food and water that simply cannot be ignored, and a social message that they may be withdrawn for the incapacitated could easily be mis-

taken for a message that it is appropriate not to care for the incapacitated.

As with the Natural Death Act and MPAA, any statute should mandate the provision of continuing support and palliative care for all patients. Further, any new act, like those acts, should contain an express prohibition of assisted suicide or euthanasia. Because this statute will be concerned with the dividing line between "allowing to die" and "killing," it would be appropriate to give concrete guidelines as to what constitutes assisted suicide or euthanasia. That enormously complex subject is scarcely considered here. Failure to give consideration to what constitutes euthanasia or assisted suicide invites future abuse; a practice the Legislature may clearly wish to prohibit and be authorized simply by affixing an appropriate label. Further, the public would benefit by a direct discussion of what is permissible, and would be disserved by an avoidance of these subjects through the subterfuge of a characterization.

IV. CONCLUSION

The Natural Death Act and the MPAA make significant strides in providing for the autonomy and welfare of citizens. Because both of those statutory provisions relate to the direction by competent adults of their own future medical treatment, the statutes enjoy wide support, notwithstanding the strong differences of opinion as to what is proper treatment in the increasingly difficult choices medicine now presents. Disputes over what is substantively correct can be smoothed over in our democracy by reference to our common belief that adults should choose for themselves in these matters.

There is no such common ground available as to the area not yet addressed by the Legislature. For those lacking capacity, one cannot simply defer to the right of the patient to choose. It may therefore be impossible to avoid addressing some of the harder questions. Nevertheless, there can be little doubt that life and death health care decisions are being made for the non-competent, and will continue to be made. Sooner or later, a dispute will reach the courts. Ignoring the unfinished work will not cause the problem to go away and, indeed, is an invitation to inconsistent and contradictory decisions being made regarding the lives and health of in-

capacitated citizens. Consideration of these topics by the Legislature, with public participation and public discussion had by groups such as the Guardianship Task Force, may not lead to a smooth resolution of all disputes. Surely, however, many areas of agreements can be found and, even where no agreement can be reached, a public debate on the most fundamental questions about human life would itself be a significant benefit to the public.