WEST virginia legislature

2022 regular session

Introduced

House Bill 4035

By Delegates Rohrbach, D Jefferies, Keaton, Lovejoy, G. Ward, Rowan and Jennings

[Introduced January 12, 2022; Referred

to the Committee on the Judiciary.]

A BILL to amend and reenact §16-30-3 and §16-30-4 of the Code of West Virginia, 1931, as amended, all relating to health care decisions; defining terms; revising forms of a living will, medical power of attorney, and combined medical power of attorney and living will and specific provisions; providing clarifying language regarding the effect of signing a living will on the availability of medically administered food and fluids; requiring oral food and fluids be provided as desired and tolerated; providing that forms executed prior to effective date of this bill remain in full force and effect; and providing for effective date.

Be it enacted by the Legislature of West Virginia:

ARTICLE 30. WEST VIRGINIA HEALTH CARE DECISIONS ACT.

§16-30-3. Definitions.

For the purposes of this article:

(~~a~~) “Actual knowledge” means the possession of information of the person’s wishes communicated to the health care provider orally or in writing by the person, the person’s medical power of attorney representative, the person’s health care surrogate, or other individuals resulting in the health care provider’s personal cognizance of these wishes. Constructive notice and other forms of imputed knowledge are not actual knowledge.

~~(b)~~ “Adult” means a person who is 18 years of age or older, an emancipated minor who has been established as such pursuant to the provisions of §49-4-115 of this code, or a mature minor.

~~(c)~~ “Advanced nurse practitioner” means a registered nurse with substantial theoretical knowledge in a specialized area of nursing practice and proficient clinical utilization of the knowledge in implementing the nursing process, and who has met the further requirements of the West Virginia Board of Examiners for Registered Professional Nurses rule, advanced practice registered nurse, 19 CSR 7, who has a mutually agreed upon association in writing with a physician, and has been selected by or assigned to the person and has primary responsibility for treatment and care of the person.

~~(d)~~ “Attending physician” means the physician selected by or assigned to the person who has primary responsibility for treatment and care of the person and who is a licensed physician. If more than one physician shares that responsibility, any of those physicians may act as the attending physician under this article.

~~(e)~~ “Capable adult” means an adult who is physically and mentally capable of making health care decisions and who is not considered a protected person pursuant to ~~the provisions of~~ Chapter 44A of this code.

~~(f)~~ “Close friend” means any adult who has exhibited significant care and concern for an incapacitated person who is willing and able to become involved in the incapacitated person’s health care and who has maintained regular contact with the incapacitated person so as to be familiar with his or her activities, health, and religious and moral beliefs.

~~(g)~~ “Death” means a finding made in accordance with accepted medical standards of either: (1) The irreversible cessation of circulatory and respiratory functions; or (2) the irreversible cessation of all functions of the entire brain, including the brain stem.

~~(h)~~ “Guardian” means a person appointed by a court pursuant to ~~the provisions of~~ Chapter 44A of this code who is responsible for the personal affairs of a protected person and includes a limited guardian or a temporary guardian.

~~(i)~~ “Health care decision” means a decision to give, withhold, or withdraw informed consent to any type of health care, including, but not limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other facility, home health care, and organ or tissue donation.

~~(j)~~ “Health care facility” means a facility commonly known by a wide variety of titles, including, but not limited to, hospital, psychiatric hospital, medical center, ambulatory health care facility, physicians’ office and clinic, extended care facility operated in connection with a hospital, nursing home, a hospital extended care facility operated in connection with a rehabilitation center, hospice, home health care, and other facility established to administer health care in its ordinary course of business or practice.

~~(k)~~ “Health care provider” means any licensed physician, dentist, nurse, physician’s assistant, paramedic, psychologist, or other person providing medical, dental, nursing, psychological, or other health care services of any kind.

~~(l)~~ “Incapacity” means the 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.

~~(m)~~ “Life-prolonging intervention” means any medical procedure or intervention that, when applied to a person, would serve to artificially prolong the dying process. ~~or maintain the person in a persistent vegetative state~~ Life-prolonging intervention includes, among other things, nutrition and hydration administered intravenously or through a feeding tube. The term “life-prolonging intervention” does not include the administration of medication or the performance of any other medical procedure considered necessary to provide comfort or to alleviate pain.

~~(n)~~ “Living will” means a written, witnessed advance directive governing the withholding or withdrawing of life-prolonging intervention, voluntarily executed by a person in accordance with the requirements of §16-30-4 of this code.

~~(o)~~ “Mature minor” means a person, less than 18 years of age, who has been determined by a qualified physician, a qualified psychologist, or an advanced nurse practitioner to have the capacity to make health care decisions.

~~(p)~~ “Medical information” or “medical records” means and includes without restriction any information recorded in any form of medium that is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school, or university or health care clearinghouse that relates to the past, present, or future physical or mental health of the person, the provision of health care to the person, or the past, present, or future payment for the provision of health care to the person.

~~(q)~~ “Medical power of attorney representative” or “representative” means a person, 18 years of age or older, appointed by another person to make health care decisions pursuant to ~~the provisions of~~ §16-30-6 of this code or similar act of another state and recognized as valid under the laws of this state.

~~(r)~~ “Parent” means a person who is another person’s natural or adoptive mother or father or who has been granted parental rights by valid court order and whose parental rights have not been terminated by a court of law.

~~(s)"Persistent vegetative state" means an irreversible state as diagnosed by the attending physician or a qualified 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~~

~~(t)~~ “Person” means an individual, a corporation, a business trust, a trust, a partnership, an association, a government, a governmental subdivision or agency, or any other legal entity.

~~(u)~~ “Physician orders for scope of treatment (POST) form” means a standardized form containing orders by a qualified physician that details a person’s life-sustaining wishes as provided by §16-30-25 of this code.

~~(v)~~ “Principal” means a person who has executed a living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will.

~~(w)~~ “Protected person” means an adult who, pursuant to ~~the provisions of~~ chapter 44A of this code, has been found by a court, because of mental impairment, to be unable to receive and evaluate information effectively or to respond to people, events, and environments to an extent that the individual lacks the capacity to: (1) Meet the essential requirements for his or her health, care, safety, habilitation, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs to provide for his or her support or for the support of legal dependents without the assistance or protection of a conservator.

~~(x)~~ “Qualified physician” means a physician licensed to practice medicine who has personally examined the person.

~~(y)~~ “Qualified psychologist” means a psychologist licensed to practice psychology who has personally examined the person.

~~(z)~~ “Surrogate decisionmaker” or “surrogate” means an individual 18 years of age or older who is reasonably available, is willing to make health care decisions on behalf of an incapacitated person, possesses the capacity to make health care decisions, and is identified or selected by the attending physician or advanced nurse practitioner in accordance with the provisions of this article as the person who is to make those decisions in accordance with the provisions of this article.

~~(aa)~~ “Terminal condition” means an incurable or irreversible condition as diagnosed by the attending physician or a qualified physician for which the administration of life-prolonging intervention will serve only to prolong the dying process.

§16-30-4. Executing a living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will.

(a) Any competent adult may execute at any time a living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will. A living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will made pursuant to this article shall be: (1) In writing; (2) executed by the principal or by another person in the principal’s presence at the principal’s express direction if the principal is physically unable to do so; (3) dated; (4) signed in the presence of two or more witnesses at least 18 years of age; and (5) signed and attested by such witnesses whose signatures and attestations shall be acknowledged before a notary public. ~~as provided in subsection (d) of this section~~

(b) In addition, a witness may not be:

(1) The person who signed the living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will on behalf of and at the direction of the principal;

(2) Related to the principal by blood or marriage;

(3) Entitled to any portion of the estate of the principal under any will of the principal or codicil thereto: *Provided,* That the validity of the living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will ~~shall~~ may not be affected when a witness at the time of witnessing ~~such~~ the living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will was unaware of being a named beneficiary of the principal’s will;

(4) Directly financially responsible for the principal’s medical care;

(5) The attending physician; or

(6) The principal’s medical power of attorney representative or successor medical power of attorney representative.

(c) The following persons may not serve as a medical power of attorney representative or successor medical power of attorney representative:

(1) A treating health care provider of the principal;

(2) An employee of a treating health care provider not related to the principal;

(3) An operator of a health care facility serving the principal; or

(4) Any person who is an employee of an operator of a health care facility serving the principal and who is not related to the principal.

(d) It ~~shall be~~ is the responsibility of the principal or his or her representative to provide for notification to his or her attending physician and other health care providers of the existence of the living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will or a revocation of the living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will. An attending physician or other health care provider, when presented with the living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will or the revocation of a living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will, shall make the living will, medical power of attorney, or combined medical power of attorney and living will or a copy of ~~either~~ any or a revocation of ~~either~~ any a part of the principal’s medical records.

(e) At the time of admission to any health care facility, each person shall be advised of the existence and availability of living will, ~~and~~ medical power of attorney, and combined medical power of attorney and living will forms and shall be given assistance in completing such forms if the person desires: *Provided,* That under no circumstances may admission to a health care facility be predicated upon a person having completed ~~either~~ a medical power of attorney, ~~or~~ living will, or combined medical power of attorney and living will.

(f) The provision of living will, ~~or~~ medical power of attorney, or combined medical power of attorney and living will forms substantially in compliance with this article by health care providers, medical practitioners, social workers, social service agencies, senior citizens centers, hospitals, nursing homes, personal care homes, community care facilities or any other similar person or group, without separate compensation, does not constitute the unauthorized practice of law.

(g) 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. Should any of the other specific directions be held to be invalid, ~~such~~ the invalidity ~~shall~~ may not affect other directions of the living will which can be given effect without the invalid direction and to this end the directions in the living will are severable.

**STATE OF WEST VIRGINIA**

**LIVING WILL**

**The Kind of Medical Treatment I Want and Don’t Want**

**If I Have a Terminal Condition ~~or Am In a Persistent Vegetative State~~**

Living will made this \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(month, year).

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (*Insert your name)*

being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and ~~not able~~ unable to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging ~~medical~~ intervention, it is my desire that my dying shall not be prolonged under the following circumstances:

If I am very sick and ~~not able~~ unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition ~~or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others).,~~ I direct that life-prolonging ~~medical~~ intervention that would serve solely to prolong the dying process ~~or maintain me in a persistent vegetative state~~ be withheld or withdrawn. I understand that this would also mean the removal of any medically administered food and fluids, such as might be provided intravenously or by feeding tube. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS: (Comments about ~~tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis,~~ funeral arrangements, autopsy, ~~and~~ mental health treatment, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

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It is my intention that this living will be honored as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences resulting from such refusal.

I understand the full import of this living will.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed

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Address

I did not sign the principal’s signature above for or at the direction of the principal. I am at least 18 years of age and am not related to the principal by blood or marriage, nor entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, ~~or~~ nor directly financially responsible for principal’s medical care. I am not the principal’s attending physician or the principal’s medical power of attorney representative or successor medical power of attorney representative under a medical power of attorney.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness DATE

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Witness DATE

STATE OF

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 COUNTY OF

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a Notary Public of said County, do certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as principal, and\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as witnesses, whose names are signed to the writing above bearing date on the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_, 20\_\_\_\_, have this day acknowledged the same before me.

Given under my hand this \_\_\_\_\_\_ day of \_\_\_\_\_\_, 20\_\_.

My commission expires:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Notary Public

(h) A medical power of attorney may, but need not, be in the following form, and may include other specific directions not inconsistent with other provisions of this article. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the medical power of attorney which can be given effect without the invalid direction and to this end the directions in the medical power of attorney are severable.

**STATE OF WEST VIRGINIA**

**MEDICAL POWER OF ATTORNEY**

**The Person I Want to Make Health Care Decisions**

**For Me When I Can’t Make Them for Myself**

Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , 20\_\_\_\_\_\_

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, ~~hereby~~

*(Insert your name ~~and address~~)*

hereby appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am ~~not~~ unable to do so myself.

**The person I choose as my representative is:**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*(Insert the name, address, area code and telephone number of the person you wish to designate as your representative.~~)~~**~~(~~Please insert only one name.)*

**If my representative is unable, unwilling, or disqualified to serve, then I appoint as my successor representative:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*(Insert the name, address, area code, and telephone number of the person you wish to designate as your successor representative.~~)~~* *Please insert only one name)*

This appointment shall extend to, but not be limited to, health care 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. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse, or withdraw such treatment or procedures. ~~Such~~ This authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician, and all legal authorities be bound by the decisions that are made by the representative appointed by this document and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated below.

~~I am giving the following~~ SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: ~~(~~Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.~~)~~

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Principal

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Principal

I did not sign the principal’s signature above. I am at least 18 years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, ~~or~~ nor legally responsible for the costs of the principal’s medical or other care. I am not the principal’s attending physician, nor am I the representative or successor representative of the principal.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness: DATE

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 Witness: DATE

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STATE OF

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNTY OF

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a Notary Public of said

County, do certify that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as principal, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as witnesses, whose names are signed to the writing above bearing date on the \_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_, have this day acknowledged the same before me.

Given under my hand this \_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

My commission expires:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

(i) A combined medical power of attorney and 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. Should any of the other specific directions be held to be invalid, ~~such~~ the invalidity does not affect other directions of the combined medical power of attorney and living will which can be given effect without the invalid direction and to this end the directions in the combined medical power of attorney and living will are severable.

**STATE OF WEST VIRGINIA**

**COMBINED MEDICAL POWER OF ATTORNEY**

**AND LIVING WILL**

**The Person I Want to Make Health Care Decisions For Me When I Can’t Make**

**Them for Myself And The Kind of Medical Treatment I Want and Don’t Want**

**If I Have a Terminal Condition ~~or Am in a Persistent Vegetative State~~**

Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, ~~hereby~~ (*Insert your name ~~and address~~*) hereby appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am ~~not~~ unable to do so myself.

**The person I choose as my representative is:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(*Insert the name, address, area code and telephone number of the person you wish to designate as your representative. Please insert only one name.*).

**If my representative is unable, unwilling, or disqualified to serve, then I appoint as my successor representative:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*(Insert the name, address, area code and telephone number of the person you wish to designate as your successor representative. Please insert only one name.*).

This appointment shall extend to, but not be limited to, health care 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. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse, or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse, or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions~~.~~, subject to the special directives and limitations as stated below:

~~I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician, and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.~~

~~It is my intent that this document be legally binding and effective and this this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.~~

~~In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directors or limitations as stated below.~~

~~I am giving the following SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments)~~

1. If I am very sick and ~~not~~ unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition~~, to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,)~~, I direct that life-prolonging ~~medical~~ intervention that would serve solely to prolong the dying process ~~or maintain me in a persistent vegetative state~~ be withheld or withdrawn. I understand that this would also mean the removal of any medically administered food and fluids, such as might be provided intravenously or by feeding tube. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated below.

2. ~~OTHER DIRECTIVES:~~ ADDITIONAL SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: Comments about feeding tubes, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.

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I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician, and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Principal

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Principal

I did not sign the principal's signature above. I am at least 18 years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, ~~or~~ nor legally responsible for the costs of the principal’s medical ~~or~~ nor other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_

STATE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a Notary Public of said county, do certify that\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as principal, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as witnesses, whose names are signed to the writing above bearing date on the \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_, have this day acknowledged the same before me.

Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_.

My commission expires:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Notary Public

(j) Any and all living will, medical power of attorney, and combined medical power of attorney and living will documents executed pursuant to §16-30-3 and§16-30-4 of this code, before the effective date of the amendments to these sections remain in full force and effect. This section is effective for a living will, medical power of attorney, and combined medical power of attorney and living will document executed, amended or adjusted on or after January 1, 2022. Accordingly, all health care facilities and health care providers using a living will, medical power of attorney, and combined medical power of attorney and living will form referenced in §16-30-4 of this code shall update their forms on or before January 1, 2022.

NOTE: The purpose of this bill is to remove the persistent vegetative state from the living will. Oral food and fluids shall be provided as tolerated in all instances.

Strike-throughs indicate language that would be stricken from a heading or the present law, and underscoring indicates new language that would be added.