# WEST VIRGINIA LEGISLATURE

## 2019 REGULAR SESSION

## Committee Substitute

## for

# Senate Bill 642

SENATORS MARONEY, AZINGER, RUCKER, TAKUBO,

TRUMP, AND ROBERTS, *original sponsors*

[Originating in the Committee on the Judiciary;

Reported on February 23, 2019]

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 providing options in living wills, and combined medical powers of attorney and living wills, that permit the principal to either be provided with medically assisted food and fluids or not to be provided with medically assisted food and fluids if the principal is unable to communicate his or her desires; redefining a term; and clarifying what constitutes a “terminal condition” and a “persistent vegetative state”.

*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 §44A-1-1 *et seq.* 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 §44A-1-1 *et seq.* 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 to 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 nor 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.

(w) "Protected person" means an adult who, pursuant to the provisions of §44A-1-1 *et seq.* 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 decision maker” 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.

(b) A living will or medical power of attorney 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 §16-30-4(d) of this code.

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

(1) The person who signed the living will or medical power of attorney 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 shall not

be affected when a witness at the time of witnessing such living will or medical power of attorney was unaware of being a named beneficiary of the principal's will;

(4) Directly financially responsible for 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)~~ (d) 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)~~ (e) It shall be 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 a revocation of the living will or medical power of attorney. An attending physician or other health care provider, when presented with the living will or medical power of attorney, or the revocation of a living will or medical power of attorney, shall make the living will, medical power of attorney, or a copy of either or a revocation of either a part of the principal's medical records.

~~(e)~~ (f) 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 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.

~~(f)~~ (g) The provision of living will or medical power of attorney 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)~~ (h) 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 invalidity shall 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,_____, being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and not able 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 to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition (an incurable or irreversible condition for which the administration of life-prolonging intervention will serve only to prolong the dying process) or to be in a persistent vegetative state (I am unconscious and am

neither aware of my environment nor able to interact with others), ~~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 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.

I, _____, wish to be provided medically assisted food (nutrition) and fluids (hydration), for example, intravenously or by feeding tube, for so long as my body is able to assimilate them, unless the provision of such becomes excessively burdensome to me, or would cause significant physical discomfort. If I am able to receive food and fluids orally, for example, by spoon and straw, I direct that such be offered to me, and shall not be denied simply because of a diagnosis of a terminal condition or persistent vegetative state. I recognize that in some cases the risk of choking may preclude the provision of food and fluids orally, in which case I direct my choice of medically assisted foods and fluids be followed.

I, _____, do not wish to be given medically assisted food (nutrition) or fluids (hydration). I understand that the removal of food and fluids may hasten or even cause my death.

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

_____

_____

_____

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

_____

_____

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, 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 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

_____ _____

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:_____

_____

Notary Public

~~(h)~~ (i) 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 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,_____, (insert your name and address) hereby ~~(Insert your name and address)~~ 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 able to do so myself.

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

_____

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

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

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

_____

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

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.

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, 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).

_____

_____

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

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 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

_____ _____

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:_____

_____

Notary Public

~~(i)~~ (j) 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 invalidity does not affect other directions of the combined medical power of attorney and living will which can be given effect without 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*) 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 able to do so myself.

The person I choose as my representative is:

_____

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

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

_____

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

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.

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).

1. If I am very sick and not able to communicate my wishes for myself and I am certified by one physician who has personally examined me, to have a terminal condition (an incurable or irreversible condition for which the administration of life-prolonging intervention will serve only to prolong the dying process) 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 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.

I, _____, wish to be provided medically assisted food (nutrition) and fluids (hydration), for example, intravenously or by feeding tube, for so long as my body is able to assimilate them, unless the provision of such becomes excessively burdensome to me, or would cause significant physical discomfort. If I am able to receive food and fluids orally, for example, by spoon and straw, I direct that such be offered to me, and shall not be denied simply because of a diagnosis of a terminal condition or persistent vegetative state. I recognize that in some cases the risk of choking

may preclude the provision of food and fluids orally, in which case I direct my choice of medically assisted foods and fluids be followed.

I, _____, do not wish to be given medically assisted food (nutrition) or fluids (hydration). I understand that the removal of food and fluids may hasten or even cause my death.

2.

Other directives:_____

_____

_____

_____

_____

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

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 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 _____

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