

# SUGGESTIONS FOR PREPARING WILL TO LIVE DURABLE POWER OF ATTORNEY

*(Please read the document itself before reading this.  
It will help you better understand the suggestions.)*

**YOU ARE NOT REQUIRED TO FILL OUT ANY PART OF THIS "WILL TO LIVE" OR ANY OTHER DOCUMENT SUCH AS A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. NO ONE MAY FORCE YOU TO SIGN THIS DOCUMENT OR ANY OTHER OF ITS KIND.**

The Will to Live form starts from the principle that the presumption should be for life. If you sign it without writing any "SPECIAL CONDITIONS," you are giving directions to your health care provider(s) and health care agent<sup>1</sup> to do their best to preserve your life.

Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

If you wish to refuse some specific medical treatment, the Will to Live form provides space to do so ("SPECIAL CONDITIONS"). You may make special conditions for your treatment when your death is imminent, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably terminally ill, meaning you will live no more than three months even if given all available medical treatment. There is also space for you to write down special conditions for circumstances you describe yourself.

The important thing for you to remember if you choose to fill out any part of the "SPECIAL CONDITIONS" sections of the Will to Live is that you must be very specific in listing what treatments you do not want. Some examples of how to be specific will be given shortly, or you may ask your physician what types of treatment might be expected in your specific case.

Why is it important to be specific? Because, given the pro-euthanasia views widespread in society and particularly among many (not all) health care providers, there is great danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

Many in the medical profession as well as in the courts are now so committed to the quality of life ethic that they take as a given that patients with severe disabilities are better off

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<sup>1</sup> Some states use the terms "attorney in fact," "surrogate," "designee," and "representative" instead of "agent." They are synonymous for purposes of these suggestions.

dead and would prefer not to receive either life-saving measures or nutrition and hydration. So pervasive is this "consensus" that it is accurate to say that in practice it is no longer true that the "presumption is for life" but rather for death. In other words, instead of assuming that a now incompetent patient would want to receive treatment and care in the absence of clear evidence to the contrary, the assumption has virtually become that since any "reasonable" person would want to exercise a "right to die," treatment and care should be withheld or withdrawn unless there is evidence to the contrary. The Will to Live is intended to maximize the chance of providing that evidence.

It is important to remember that you are writing a legal document, not holding a conversation, and not writing a moral textbook. The language you or a religious or moral leader might use in discussing what is and is not moral to refuse is, from a legal standpoint, often much too vague. Therefore, it is subject to misunderstanding or deliberate abuse.

The person you appoint as your health care agent may understand general terms in the same way you do. But remember that the person you appoint may die, or become incapacitated, or simply be unavailable when decisions must be made about your health care. If any of these happens, a court might appoint someone else you don't know in that person's place. Also remember that since the agent has to follow the instructions you write in this form, a health care provider could try to persuade a court that the agent isn't really following your wishes. A court could overrule your agent's insistence on treatment in cases in which the court interprets any vague language you put in your "Will to Live" less protectively than you meant it.

So, for example, do not simply say you don't want "extraordinary treatment." Whatever the value of that language in moral discussions, there is so much debate over what it means legally that it could be interpreted very broadly by a doctor or a court. For instance, it might be interpreted to require starving you to death when you have a disability, even if you are in no danger of death if you are fed.

For the same reason, do not use language rejecting treatment which has a phrase like "excessive pain, expense or other excessive burden." Doctors and courts may have a very different definition of what is "excessive" or a "burden" than you do. Do not use language that rejects treatment that "does not offer a reasonable hope of benefit." "Benefit" is a legally vague term. If you had a significant disability, a health care provider or court might think you would want no medical treatment at all, since many doctors and judges unfortunately believe there is no "benefit" to life with a severe disability.

What sort of language is specific enough if you wish to write exclusions? Here are some examples of things you might--or might not--want to list under one or more of the "Special Conditions" described on the form. Remember that any of these will prevent treatment ONLY under the circumstances--such as when death is imminent--described in the "Special Condition" you list it under. (The examples are not meant to be all inclusive--just samples of the type of thing you might want to write.)

"Cardiopulmonary resuscitation (CPR)." (If you would like CPR in some but not all

circumstances when you are terminally ill, you should try to be still more specific: for example, you might write "CPR if cardiopulmonary arrest has been caused by my terminal illness or a complication of it." This would mean that you would still get CPR if, for example, you were the victim of smoke inhalation in a fire.) "Organ transplants." (Again, you could be still more specific, rejecting, for example, just a "heart transplant.")

"Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer."

"A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me."

### **Pain Relief**

Under the "General Presumption for Life," of your Will to Live, you will be given medication necessary to control any pain you may have "as long as the medication is not used in order to cause my death." This means that you may be given pain medication that has the secondary, but unintended, effect of shortening your life. If this is not your wish, you may want to write something like one of the following under the third set of "Special Conditions" (the section for conditions you describe yourself):

"I would like medication to relieve my pain but only to the extent the medication would not seriously threaten to shorten my life." OR

"I would like medication to relieve my pain but only to the extent it is known, to a reasonable medical certainty, that it will not shorten my life."

Think carefully about any special conditions you decide to write in your "Will to Live." You may want to show them to your intended agent and a couple of other people to see if they find them clear and if they mean the same thing to them as they mean to you. Remember that how carefully you write may literally be a matter of life or death--your own.

**AFTER WRITING DOWN YOUR SPECIAL CONDITIONS, IF ANY, YOU SHOULD MARK OUT THE REST OF THE BLANK LINES LEFT ON THE FORM FOR THEM (JUST AS YOU DO AFTER WRITING OUT THE AMOUNT ON A CHECK) TO PREVENT ANY DANGER THAT SOMEBODY OTHER THAN YOU COULD WRITE IN SOMETHING ELSE.**

**IT IS WISE TO REVIEW YOUR WILL TO LIVE PERIODICALLY TO ENSURE THAT IT STILL GIVES THE DIRECTIONS YOU WANT FOLLOWED.**

Robert Powell Center for Medical Ethics  
National Right to Life  
[www.nrlc.org](http://www.nrlc.org) ~ (202) 378-8863

# How to use the West Virginia Will to Live Form

## SUGGESTIONS AND REQUIREMENTS

1. This document allows you to designate (name) a health care representative who will make health care decisions for you whenever you are unable to make them for yourself. It also allows you to give instructions concerning medical treatment decisions that the health care representative must follow. Any person who is at least 18 years old may designate a health care representative through this document.
2. You must do BOTH of the following to properly designate a health care representative through this document:
  - A.) Sign and date this document in the presence of two witnesses who are each at least 18 years old. (If you are unable to sign and date the document yourself, you may direct someone to do it for you in your presence.) The two witnesses must sign the document in your presence and in each other's presence; AND
  - B.) Have it notarized by a notary public.
3. The witnesses must each be at least 18 years old. Neither witness nor a notary can be:
  - the person who signed the medical power of attorney on your behalf or at your direction;
  - related to you by blood or marriage;
  - entitled to any portion of your estate by an existing will or the laws of West Virginia (although the witness will be valid if the witness was unaware at the time of witnessing that he or she was named in your will);
  - legally responsible for your medical costs or medical care
  - the attending physician; or
  - the representative or any successor representative appointed pursuant to this article.
4. Your health care representative and successor representatives must be at least 18 years of age. Your health care representative must NOT be:
  - your treating health care provider;
  - an employee of a treating health care provider not related to you;
  - an operator of a health care facility serving you; or
  - an employee of an operator of a health care facility not related to the principal.
5. It is helpful to designate successor health care representative(s), to take over if your first choice is unable to serve. There is space on this form for you to designate a successor health care representative.

6. You should tell your doctor about this document. You should also ask your doctor to keep a copy of this document as a part of your medical health record.
7. Your health care representative's authority takes effect only when you no longer have the capacity to make and communicate your own health care decisions.
8. The document will remain in effect until you revoke (cancel) it. You may revoke this document at any time. The revocation of the document may be:
  - written, signed and dated by you or the person acting under your authority;
  - oral, in the presence of a witness eighteen years or older who signs and dates a writing confirming that such a decision was made; or
  - by destruction of the document by you or at your direction.

In addition, if you sign a new document naming a health care representative, you will revoke this document unless the new document specifically states otherwise.

A written or oral revocation will take effect only when communicated to the attending physician. The attending physician must record in your medical record the time and place in which the revocation was received.

If your Medical Power of Attorney names your spouse as your health care representative or successor health care representative, that designation is automatically revoked by a final decree of divorce.

9. This type of document has been authorized by the West Virginia Health Care Decisions Act, § 16-30-1 - § 16-30-25.
10. You should periodically review your document to be sure it complies with your wishes. Before making any changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting [www.nrlc.org](http://www.nrlc.org) (Click on "Will to Live") or an attorney to determine if this form can still be used.
11. If you have any questions about this document, or want assistance in filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit [www.nrlc.org](http://www.nrlc.org)

Form prepared 1992  
\*updated 10/15

**West Virginia Medical Power of Attorney  
Will to Live Form**

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

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

(your address)\_\_\_\_\_

(your phone number)\_\_\_\_\_

hereby appoint:

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

(designate's name)\_\_\_\_\_

(designate's address)\_\_\_\_\_

(designate's phone number(s))\_\_\_\_\_

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

(successor's name)\_\_\_\_\_

(successor's address)\_\_\_\_\_

(successor's phone number(s))\_\_\_\_\_

as my 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 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 interests 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 interest 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. In the event that the law does not recognize this document as legally binding and effective, it is my intent 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.

### **GENERAL PRESUMPTION FOR LIFE**

I direct my health care provider(s) and health care representative to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care attorney in fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named below, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special conditions.

**WHEN MY DEATH IS IMMINENT**

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me **and** in the opinion of two physicians who have personally examined me, one of whom is my attending physician, life-prolonging intervention offers no medical hope of benefit – the following may be withheld or withdrawn:

**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)



**WHEN I AM TERMINALLY ILL**

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me **and** in the opinion of two physicians who have personally examined me, one of whom is my attending physician, life-prolonging intervention offers no medical hope of benefit – the following may be withheld or withdrawn: **(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**C. OTHER SPECIAL CONDITIONS:**  
**(Be as specific as possible; SEE SUGGESTIONS):**

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(Cross off any remaining blank lines.)

**IF I AM PREGNANT**

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care representative(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

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Signature of Declarant

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

These directives shall supercede any directives made in any previously executed document concerning my health care.

(Signature) \_\_\_\_\_

(Date) \_\_\_\_\_

**WITNESSES**

I did not sign the principal's signature above. I am at least eighteen 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 according to the laws of intestate succession of the state of the principal's domicile or to the best of my knowledge under a 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.

First Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Second Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

to-wit:

**NOTARY PUBLIC**

State of West Virginia

County of \_\_\_\_\_

I, (name of notary public) \_\_\_\_\_ a Notary

Public of said County, do certify that (name of principal) \_\_\_\_\_,

as principal, and (names of witnesses) \_\_\_\_\_,

as witnesses, whose names are signed to the writing above bearing the date on the day of

\_\_\_\_\_, 20\_\_\_\_, have this day acknowledged the same before me.

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

Notary Seal

Signature of Notary Public \_\_\_\_\_

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

Form prepared 1992  
\*clerical changes made 10/15