

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 agent¹ 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

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

quality of life ethic that they take as a given that patients with severe disabilities are better off 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 ~ (202) 378-8862

How to use the Tennessee Will to Live Form SUGGESTIONS AND REQUIREMENTS

1. This document allows you to appoint an “Attorney-in-fact” for health care (also called a health care agent). You are appointing this individual to make health care decisions for you whenever you are unable to make such decisions for yourself. The individual you appoint as your Attorney-in-Fact does not have to be a lawyer. This document also allows you to give instructions concerning medical treatment decisions which your Attorney-in-Fact must follow.
2. The authority of your Attorney-in-Fact for health care takes effect only when you no longer have the capacity to make and communicate your own health care decisions.
3. You must sign and date this document in the presence of a Notary Public AND two witnesses.
4. Neither of the witnesses can be the person you named as your Attorney-in-Fact for health care, nor can you name your conservator as a witness. At least one of the witnesses must NOT be a person related to you by blood, marriage or adoption, or entitled to inherit anything from you under your will or as an heir.
5. The person you name as your Attorney-in-Fact for health care cannot be a health care provider, an employee of a health care provider, the operator of a health care institution or the employee of a health care institution, unless such person is related to you by blood, marriage, or adoption, and all other requirements for a durable power of attorney are satisfied. Further, neither your treating physician and/or health care provider nor their employees can be a witness.
6. If you are a conservatee, you may not designate your conservator as your attorney in fact to make health care decisions unless you are represented by an attorney, and the attorney representing you signs a certificate stating in substance:

“I am an attorney authorized to practice in the state where this power of attorney was executed, and the principal was my client at the time this power of attorney was executed. I have advised my client concerning my client’s rights in connection with this power of attorney and the applicable law, and the consequences of signing or not signing this power of attorney, and my client, after being so advised, has executed this durable power of attorney for health care.”
7. There is space on the form for you to designate two alternate Attorneys-in-Fact for health care. It is helpful to designate alternate Attorneys-in-Fact for health care to take over if your first choice is unable to serve.

8. 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 record. Give copies of the signed original to your Attorney-in-Fact for health care, family members, and anyone else you think appropriate. Keep the original document in a safe place that will be easily accessible to others in case of an emergency and tell someone where it is located.
9. The “WARNING TO PERSON EXECUTING THIS DOCUMENT” is required by Tennessee law to be included in this form. The Will to Live language included within this document is consistent with the presumption for life and should be filled out in accordance with your wishes.
10. The durable power of attorney for health care will remain in effect until you revoke (cancel) it. You can revoke that appointment of your Attorney-in-Fact by notifying your Attorney-in-Fact either orally or in writing, or you can revoke the authority granted to the Attorney-in-Fact by notifying your health care provider either orally or in writing. You must notify or otherwise make it known to your named Attorney-in-Fact that the Power of Attorney has been revoked if such revocation was by communication to the health care provider. If you name your spouse as your Attorney-in-Fact for health care and your marriage is dissolved or annulled, the appointment of your spouse as your Attorney-in-Fact is automatically revoked unless the durable power of attorney document expressly states otherwise. If you execute a new valid durable power of attorney appointing an Attorney-in-Fact for health care, you will revoke this document unless the new power of attorney for health care states otherwise.
11. This document has been authorized by the Tennessee Right to Natural Death Act, Tenn. Code Ann. Sections 32-11-101 to 32-11-112 as well as the Tennessee Durable Power of Attorney for Health Care Act, Tenn. Code Ann. Sections 34-6-201 to 34-6-216.
12. 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 (click on “Will to Live”) or any attorney to determine if this form can still be used.
13. If you have any questions about this document or want assistance filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit www.nrlc.org.

Tennessee Durable Power of Attorney for Health Care Will to Live Form

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document you should know these important facts.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations you include in this document. You may state in this document any types of treatment you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____
(your name)

Address _____

(your address)

Telephone _____,
(your telephone number(s))

state and affirm that I have read the foregoing paragraphs concerning the legal consequences of my executing this document, and I do hereby appoint

(attorney-in-fact's name) _____

(attorney-in-fact's address) _____

(attorney-in-fact's phone number(s)) _____

as my attorney in fact to make any health care decisions for me as authorized in this document consistent with the instructions below.

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint the following persons (each to act alone and successively, in the order named):

A. First Alternate Attorney-in-Fact

(name) _____

(address) _____

(phone number(s)) _____

B. Second Alternate Attorney-in-Fact

(name) _____

(address) _____

(phone number(s)) _____

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care attorney in fact(s) 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.

The instructions in this document are intended to be followed even if suicide is alleged to be attempted at some point after it is signed.

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 attorney in fact to follow the above policy, 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 – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

(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 – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

C. OTHER SPECIAL CONDITIONS:

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

(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 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.

Signature

This power of attorney becomes effective when I can no longer make my own medical decisions and shall not be affected by my subsequent disability or incompetence. The determination of whether I can make my own medical decisions is to be made by my attorney in fact, or if he or she is unable, unwilling or unavailable to act, by my alternate attorney in fact.

IN WITNESS WHEREOF, I have set my hand this ____ day of _____, _____.

(Signature)

I declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to me to be the principal; that the principal signed this durable power of attorney document in my presence; that the principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as attorney in fact by this document; that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the principal by blood or marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon his death; and that, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will of codicil thereto now existing, or by operation of law.

Signature of First Witness _____

Name _____

Address _____

Signature of Second Witness _____

Name _____

Address _____

Acknowledgment by Notary Public

STATE OF TENNESSEE

COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____, the
declarant, and subscribed and sworn to before me by _____ and
_____, witnesses, this _____ day of _____, 20__.

Notary Public

My Commission Expires:
