

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 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

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

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 Michigan Will to Live Form Suggestions and Requirements:

1. This document allows you to name a patient advocate who will make health care decisions for you whenever you are unable to make them for yourself. (“Patient advocate” is the term used in Michigan law for a health care agent.) It also allows you to give instructions concerning medical treatment decisions that the agent must follow. Any person who is of sound mind and is at least 18 years old may designate a patient advocate through this document.
2. You may appoint ANY person who is at least 18 years of age to be your advocate, including your spouse, child, relative, associate, etc. **It is important that you consult with the person you are naming as your patient advocate and secure his or her consent before naming that person.**
3. It is helpful to name successor patient advocate(s) to take over if your first patient advocate is unable to serve. There is space on the form for you to name two successor patient advocates.
4. To properly complete this document, you must sign and date it in the presence of two witnesses. The witnesses must not be your spouse, your parent, your child, your grandchild, your sibling, your physician, your patient advocate, an employee of your life or health insurer, an employee of a health facility treating you, an employee of a nursing home where you reside, a beneficiary of your will (the legal term is “known devisee”), or any person who might inherit property from you if you did not have a will (the legal term is “presumptive heir”).
5. Before acting as your patient advocate, your proposed patient advocate and successor patient advocate(s) must sign an acceptance of your appointment of them as your patient advocate and successor patient advocate(s). Your patient advocate and successor patient advocate(s) should sign the acceptance as soon as possible after or at the same time as you sign your Will to Live form. The advocate acceptance statement is at the end of the Will to Live form.
6. Your patient advocate’s authority takes effect only when you have been determined to be “unable to participate in medical decisions.” Your attending doctor and another doctor or psychologist must make this determination based on an examination of you, put it in writing in your medical record, and review it at least once every year.
It is very important for you to recognize that your being “unable to participate in medical treatment decisions” includes a range of conditions, from being fully conscious but incompetent due to injury or mental illness, to being completely unconscious and unaware of your environment.

7. Even if you are considered incompetent or unable to participate in care, custody, or medical treatment decisions, if you ever ask to be given any specific life extending care, custody, or medical treatment, that request will be binding on your patient advocate regardless of what you may previously have directed in this document or otherwise.
8. The document will remain in effect until you revoke (cancel) it. You may revoke this document (in whole or in part) or limit your patient advocate's authority at any time. You may revoke it either orally or in writing. If done orally, a witness to your revocation should describe in writing the circumstances of your revocation, sign the writing, and notify your patient advocate. The document is also revoked: (1) upon your death, (2) if a probate court orders it dissolved, (3) if you did not name a successor patient advocate and your patient advocate either resigns or is removed by the probate court, (4) if you complete a new document naming a patient advocate, or (5) when you legally separate, divorce or are granted an annulment from your spouse, if during your marriage you named your spouse as your patient advocate and did not name a successor patient advocate. If you or your spouse has filed for separation, divorce, or annulment, the designation is suspended (has no effect) until there is a final ruling in the case.

If you do complete a new Durable Power of Attorney for Health Care, be sure to distribute copies of the new document to anyone who has a copy of an existing Durable Power of Attorney for Health Care.
9. To be effective, this designation must be made a part of your medical record with your attending doctor and also with any nursing home or health care facility where you may be. Therefore, you should give a copy to your doctor and to any nursing home or health care facility where you are or become a resident or patient.

You should also give copies to your patient advocate and successor patient advocate(s) and to other people who would be concerned for your health care: thus, you might consider giving a copy to family members, clergy, and your lawyer.
10. This type of document has been authorized by the Michigan Durable Power of Attorney for Health Care Act, Mich. Comp. Laws, § 700.5501 through §700.5513.
11. 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 an attorney to determine if this form can still be used.
12. 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 and click on "Will to Live"

Will to Live
MICHIGAN DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

I, _____
(Your name)
of _____
(Full legal address) Telephone _____

hereby appoint _____
(Name of your designated patient advocate)
residing at _____
(Full legal address) Telephone _____

as my agent in fact (herein called advocate) with the following power to be exercised in my name and for my benefit, for the purposes of making decisions regarding my care, custody, or medical treatment. This Durable Power of Attorney shall not be affected by my disability or incapacity, and is governed by Section 700.5501 et seq. of the Michigan Compiled Laws.

In the event that the above-named advocate is unable, or expresses an intent not to serve as my advocate, I then appoint

_____ (Name of your successor advocate)
residing at _____
(Full legal address) Telephone _____

to serve as my successor advocate.

In the event that both the above-named advocate and successor advocate are unable, or express an intent not to serve as my advocate, I then appoint:

_____ (Name of second successor advocate)
residing at _____
(Full legal address) Telephone _____

to serve as my successor advocate.

This Durable Power of Attorney shall be exercisable only when I am unable to participate in medical treatment decisions the determination of my ability to participate in treatment decisions shall be made by my attending physician and at least one other physician or licensed psychologist.

Before the powers granted in this durable power of attorney are exercisable, a copy of it shall be placed in my medical records along with the written determination of my incompetence. I retain the right to revoke the Durable Power of Attorney at any time, and by any means whereby I may communicate a desire to revoke it.

II. Desires and Preferences for Treatment

I understand that my inability to participate in medical treatment decisions may encompass a wide range of circumstances, including, but not limited to, my being either (a) conscious, but mentally incompetent, or (b) unconscious and unaware. My desires and preferences for treatment include: (You may add additional pages if needed.)

GENERAL PRESUMPTION FOR LIFE

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

During the time I am incompetent, my patient advocate(s), as named above, 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 instructions.

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 my 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.)

This section is part of my declaration in the event that judicial decision or legislative act alters or makes invalid Mich. Comp. Laws Serv. § 750.322 so as to allow this declaration to have force during pregnancy.

IF I AM PREGNANT

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and patient advocate(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

III. Signature and Witnessing

I have discussed this designation with my above-named advocate, who intends to sign the attached acceptance to this designation (check one)

Concurrently with the execution of this document.

At a future date.

I freely and voluntarily sign this document, in the presence of the below-named witnesses, and it shall become effective on the date indicated below.

(Signature)

(date)

Statement of Witnesses

As a witness to the execution of this Durable Power of Attorney I attest that the person who has signed this document in my presence appears to be of sound mind and under no duress, fraud, or undue influence. I further attest that I am not the person's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee, physician, the named advocate, an employee of a life or health insurance provider for the person, or an employee of a health facility or home for the aged that is treating the person.

(Witness Signature)

(Address)

(Type or Print Name)

(City, State, Zip)

(Witness Signature)

(Address)

(Type or Print Name)

(City, State, Zip)

IV. Acceptance of Power of Attorney

We hereby accept the responsibilities conferred upon us by _____
(Type or print name of principal)

to serve as patient advocate in the document executed on _____
(Date)

We maintain the right to revoke this acceptance at any time, and by any means whereby we may communicate a desire to revoke it. By providing our signatures below we acknowledge that we have read and understand the following requirements of Michigan law pertaining to the execution of a Durable Power of Attorney for Health Care.

(A) This designation shall not become effective unless the patient is unable to participate in treatment decisions.

(B) A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(C) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(D) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(E) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(F) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidence while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(I) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act. No. 368 of the Public Acts of 1978, being section 333.20201 of the Michigan Compiled Laws.

Patients and residents are also entitled to:

- inspect their medical record, and to have the confidentiality of that record maintained.
- receive adequate and appropriate care, and receive information in terms which the patient or resident can understand about one's medical condition, proposed course of treatment, and prospects for recovery.
- refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. When a refusal of treatment prevents a health facility or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient or resident may be terminated upon reasonable notice.
- information about the health facility's rules and regulations affecting patient or resident care and conduct; and information about the facility's policies and procedures for initiation, review, and resolution of patient complaints.
- receive and examine an explanation of his or her bill regardless of the source of payment and to receive, upon request, information relating to financial assistance available through the facility.

- associate and have private communications with a physician, attorney, or any other person, and to send and receive personal mail unopened.
- be free from mental and physical abuse and from physical and mental restraint, except in circumstances necessary to protect the patient or others from injury.

(Advocate's signature)

(Date)

(Address, City, State, Zip)

(First Successor Advocate's signature)

(Date)

(Address, City, State, Zip)

(Second Successor Advocate's signature)

(Date)

(Address, City, State, Zip)

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