

# 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

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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.

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](http://www.nrlc.org) ~ (202) 378-8862

# How to use the North Dakota Will to Live Form

## SUGGESTIONS AND REQUIREMENTS

1. This document allows you to appoint an “attorney in fact” for health care – someone who does NOT have to be a lawyer, 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 agent must follow. Any resident of North Dakota who is at least 18 years old may designate a health care agent through this document.
2. The “Warning to Person Executing This Document” and the rest of the document, contain important information about who cannot be named as your agent and about witnessing requirements. You should read them carefully before you begin to fill it out.
3. It is helpful to designate successor health care agent(s), to take over if your first choice is unable to serve. There is space on the form for you to designate two successor health care agents.
4. If you are resident of a “long-term care facility” such as a nursing home, one of the following must sign a statement that the person has explained the nature and effect of this document to you:
  - recognized member of the clergy
  - lawyer licensed in North Dakota
  - person designated by the North Dakota Department of Human Services or the county court from the county in which the facility is located.A form for that statement is on the next page. If this applies to you, you should keep it with your Will to Live.
5. If you are a patient in a hospital, or being admitted to a hospital, when you complete this document, a person designated by the hospital must sign a statement that the person has explained the nature and effect of this document to you. A form for that statement is also on the next page. If this applies to you, you should keep it with your Will to Live.
6. This type of document has been authorized by the North Dakota Durable Power of Attorney for Health Care Act, N.D. Cent. Stat. §§ 23-06.501 to -18.
7. You should periodically review your document to be sure it complies with your wishes. Before making 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.

8. 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)

**If you are in a nursing home, the following form must also be completed at the time you sign your Will to Live:**

**Affirmation of Explanation to Resident of Nursing Home**

I, \_\_\_\_\_, affirm that I have explained the nature and effect of the durable power of attorney for health care to \_\_\_\_\_, who is currently a resident of a long term care facility named \_\_\_\_\_, in the County of \_\_\_\_\_, North Dakota, that I have done so at the time she or he is executing the durable power of attorney for health care, and that I am (mark one):

- \_\_\_ a recognized member of the clergy
- \_\_\_ an attorney licensed to practice in North Dakota
- \_\_\_ a person designated by the North Dakota Department of Human Services
- \_\_\_ a person designated by the County Court of \_\_\_\_\_ County

Signed on \_\_\_\_\_ (date)

\_\_\_\_\_  
Signature

Address: \_\_\_\_\_  
\_\_\_\_\_

**If you are being admitted to or are a patient in a hospital, the following form must also be completed at the time you sign your Will to Live:**

**Affirmation of Explanation to Resident of Nursing Home**

I, \_\_\_\_\_, affirm that I have explained the nature and effect of the durable power of attorney for health care to \_\_\_\_\_, who is a patient being admitted to \_\_\_\_\_ Hospital, that I have done so at the time she or he is executing the durable power of attorney for health care, and that I have been designated by the hospital to do this.

Signed on \_\_\_\_\_ (date)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Hospital Position

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_

**North Dakota**  
**Statutory Form Durable Power of Attorney for Health Care**  
**Will to Live Form**

**WARNING TO PERSON EXECUTING THIS DOCUMENT**

***This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:***

**You must be at least eighteen years of age for this document to be legally valid and binding.**

**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 or otherwise made known.**

**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.**

**This document gives your agent authority to request, to consent to, or withdraw consent for any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that 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 authorizes anything is illegal, acts contrary to your known desires, or where your desires are not known, does anything that is clearly contrary to your best interest.**

**Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death.**

**You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, 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.**

**This document revokes any prior durable power of attorney for health care.**

**You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.**

**If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.**

**Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents, if any, or give each of them an executed copy of this document. You should give your doctor an executed copy of this document.**

**1. DESIGNATION OF HEALTH CARE AGENT.**

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

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

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

do hereby designate and appoint: \_\_\_\_\_

*(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: your treating health care provider, a nonrelative employee of your treating health care provider, an operator of a long-term health care facility; or a nonrelative employee of an operator of a long-term care facility)*

as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

**2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.** By this document I intend to create a durable power of attorney for health care.

**3. GENERAL STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

*(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 below. You can indicate your desires by including a statement of your desires in the same paragraph.)*

**4. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS.**

*(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should*

*state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

- a. Statement of desires concerning life-prolonging care, treatment, services and procedures:

### **GENERAL PRESUMPTION FOR LIFE**

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

\_\_\_\_\_  
Signature of Declarant

b. Additional Statement of desires, special provisions, and limitations regarding health care decisions:

See above instructions

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*(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)*

If you wish to make a gift of any bodily organ you may do so pursuant to North Dakota Century Code chapter 23-06.2, the Uniform Anatomical Gift Act.

**5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.** Subject to any limitations in this document, my agent has the power and authority to do all of the following:

- (a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records.
- (b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- (c) Consent to the disclosure of this information.

*(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 above.)*

**6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES.** Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

- (a) Documents titled or purporting to be a “Refusal to Permit Treatment” and “Leaving Hospital Against Medical Advice.”
- (b) Any necessary waiver or release from liability required by a hospital or physician.

**7. DURATION**

*(Unless you specify a shorter period of time in the space below, this power of attorney will exist until it is revoked.)*

This durable power of attorney for health care expires on \_\_\_\_\_.

*(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)*

**8. DESIGNATION OF ALTERNATE AGENTS**

*(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)*

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person’s appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent

(name) \_\_\_\_\_

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

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

B. Second Alternate Agent

(name) \_\_\_\_\_

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

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

**9. PRIOR DESIGNATIONS REVOKED.** I revoke any prior durable power of attorney for health care.

**DATE AND SIGNATURE OF PRINCIPAL**  
(You must date and sign this Power of Attorney)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

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

at  
(City, State) \_\_\_\_\_

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

**(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)**

NOTARY PUBLIC OR STATEMENT OF WITNESSES

This document must be notarized or witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider providing your care. At least one witness to the execution of the document must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care. None of the following may be used as a notary or witness:

1. A person who you designate as your agent or alternate agent;
2. Your spouse;
3. A person related to you by blood, marriage, or adoption;
4. A person entitled to inherit any part of your estate upon your death;
5. A person who has, at the time of executing this document, any claim against your estate;
6. A person directly financially responsible for the principal’s medical care; or
7. The attending physician of the principal.

OPTION 1: NOTARY PUBLIC

In my presence on \_\_\_\_\_(date), \_\_\_\_\_(name of declarant) acknowledged the declarant’s signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant’s behalf.

[Notary Stamp]

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

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

OPTION 2: TWO WITNESSES

Witness One:

(1) In my presence on \_\_\_\_\_(date), \_\_\_\_\_(name of declarant) acknowledged the declarant’s signature on this document or acknowledged that the declarant directed the person signing this document to sign on the delcarant’s behalf.

(2) I am at least 18 years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [ ]

I certify that the information in (1) through (3) is true and correct.

Signature of Witness One \_\_\_\_\_

Address: \_\_\_\_\_

Witness Two:

(1) In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

(2) I am at least 18 years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box: [    ]

I certify that the information in (1) through (3) is true and correct.

Signature of Witness Two \_\_\_\_\_

Address: \_\_\_\_\_

**10. ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY.** I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time and in any manner.

If I choose to withdraw during the time the principal is competent I must notify the principal of my decision. If I choose to withdraw when the principal is incapable of making the principal's health care decisions, I must notify the principal's physician.

\_\_\_\_\_  
*signature of agent/date*

\_\_\_\_\_  
*signature of first alternate agent/date*

\_\_\_\_\_  
*signature of second alternate agent/date*

form prepared 2001  
\*clerical changes made 11/05