

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.

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

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 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) 378-8863

How to use the Washington Will to Live Form -- SUGGESTIONS AND REQUIREMENTS:

1. This document allows you to name an attorney-in-fact for health care 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 attorney-in-fact must follow. For this document to be valid you must sign and date this document before a Notary Public OR have it signed and dated by two witnesses.
The witnesses cannot be
 - related to you by blood, marriage, or domestic partnership
 - your home care provider
 - or your long term care facility provider
2. None of the following persons may act as your attorney-in-fact: any of your doctors, your doctors' employees, or the owners, administrators, or employees of the health care facility in which you reside or receive care. However, you may name as your attorney-in-fact any person listed above if that person is your spouse, or your adult child, or your brother or sister.
3. It is helpful to appoint a successor attorney-in-fact, in the event that your first attorney-in-fact is unable to serve. There is a space on the form for you to name two successor attorneys-in-fact.
4. You should tell your doctor about this document and ask him or her to keep a copy of it in your medical file.
5. Your attorney-in-fact's authority takes effect only when you no longer have the capacity to make health care decisions.
6. This type of document has been authorized by Washington Rev. Code § 7.70.065 and "The Uniform Power of Attorney Act" Washington Rev. Code §11.125.010 to .903.
7. No fee may be charged for the preparation of this document.
8. 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.
9. If you have 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
and click on "Will to Live" Form Prepared 2001 Clerical Changes Made 2017

**Washington Durable Power of Attorney
WILL TO LIVE FORM**

I, _____, domiciled and living in the state of Washington,
(your name)

hereby designate (name of attorney-in-fact) _____

living at (address and telephone number) _____

as my attorney-in-fact.

If the attorney-in-fact appointed above is unable to serve, then I appoint (name of successor attorney-in-fact) _____ living at (address and telephone number) _____

to serve as successor attorney-in-fact in place of the person who is unable to serve.

If neither is able to serve, then I appoint (name of successor attorney-in-fact) _____ living at (address and telephone number) _____

to serve as successor attorney-in-fact in place of the persons who are unable to serve.

In the event I become disabled or incompetent, my attorney-in-fact shall have all powers as are necessary to provide for my health and to consent to health care as provided in the Revised Code of Washington Annotated section 7.70.065(b) in accordance with the following instructions.

GENERAL PRESUMPTION FOR LIFE

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

(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 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 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 Principal

HIPPA RELEASE AUTHORITY

I intend for my attorney-in-fact to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA) 42USC 1320d and 45 CFR 160-164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc or other health care clearinghouse that has provided treatment or services to me or that has been paid for or is seeking payment from me for such services to give, disclose and release to my attorney-in- fact, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition. The authority given my attorney-in-fact has no expiration date and shall expire only in the event that I revoke the authority and deliver it to my health care provider.

The authority given my attorney-in-fact shall supersede any prior agreement that I may have with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my attorney-in-fact has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

Furthermore, and pursuant to 45 CFR Part 160-164 and Sec. 264 of the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, ("HIPAA"), my attorney-in-fact is specifically authorized to act as my "personal representative" for the purpose of acting on my behalf and to exercise any rights on my behalf under HIPAA”

Signature of Principal

FIRST ALTERNATIVE: WITNESS DECLARATION

I declare that the person who signed this document is personally known to me, that s/he signed this durable power of attorney in my presence, and that s/he appears to be of sound mind and under no duress, fraud or undue influence. I am not the person designated as attorney in fact by this document, nor related to them by blood, marriage, or civil partnership, nor am I the principal's health care provider, home care provider or an employee of the principal's health care provider. I am at least eighteen years of age.

First Witness Signature: _____

Date: _____ Print Name: _____

Address: _____

Phone Number: _____

Second Witness Signature: _____

Date: _____ Print Name: _____

Address: _____

Phone Number: _____

SECOND ALTERNATIVE: NOTARIZATION

This power of attorney shall become effective in the event I become disabled or incompetent.

This power of attorney may be revoked in writing by my giving written notice to the attorney-in-fact, or if applicable, to the successor attorney-in-fact.

DATED _____, _____.

(your signature)

STATE OF WASHINGTON)

) ss

COUNTY OF _____)

I certify that I know or have satisfactory evidence that (name) _____
signed this instrument and acknowledged it to be his or her free and voluntary act for the use
and purposes mentioned in the instrument.

(Date)

(Notary Public)

My Appointment Expires:
