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[1] 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 <u>do</u> 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

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[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 District of Columbia Will to Live Form
SUGGESTIONS AND REQUIREMENTS

1. This document allows you to appoint (name) an "attorney in fact" (also called a health care agent) – 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 attorney in fact must follow. Any adult person who is competent to make his or her own health care decisions may designate an attorney in fact through this document.

2. It is helpful to appoint successor attorneys in fact, to take over if your first choice is unable to serve. There is space on the form for you to designate two successor attorneys in fact.

3. Your attorney in fact's authority takes effect only when you no longer have the capacity to make and communicate your own health care decisions. Two physicians, one of whom must be a psychiatrist, must certify in writing that your are unable to make health care decisions for yourself.

4. You must sign and date this document in the presence of two adult witnesses who are personally known to you. The two witnesses must sign the document in your presence and in each other's presence.

5. Neither of the witnesses can be the person you named as your attorney in fact, your doctor, or other licensed health care provider, or an employee of your health care provider or facility. At least one of the witnesses must be a person who is neither related to you by blood, marriage or adoption, nor entitled to inherit anything from you under your will or as an heir.

6. The document will remain in effect until you revoke (cancel) it. You may revoke this document at any time. To do so, you can either:
   - notify your attorney in fact orally or in writing that you wish to revoke his or her appointment as your attorney in fact, or
   - notify your doctor or health care facility orally or in writing that you wish to revoke the authority you granted to your attorney in fact to make health care decisions for you.

   If you execute a new document naming an attorney in fact, that will revoke this document unless the new document specifically says otherwise. If you choose your spouse as your attorney in fact and your marriage is dissolved or annulled, the designation of your former spouse as your attorney in fact will be automatically revoked. (If you later

remarry the spouse from whom you were divorced, however, that person will again become your attorney in fact.)

7. You should tell your doctor about this document. You should also ask your doctor to keep a copy of this document as part of your medical health record. Give copies of the signed original to your attorney in fact, 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.

8. This type of document has been authorized by the District of Columbia Health Care Decisions Act of 1988, D.C. Code Ann. §§21-2201 to 21-2213.

9. 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.

10. 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

Form prepared 2002
Clerical changes made 2008
Reviewed 2013

District of Columbia
Durable Power of Attorney for Health Care
Will to Live Form

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, IT IS VITAL FOR YOU TO KNOW AND UNDERSTAND THESE FACTS:

- THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR ATTORNEY IN FACT THE POWER TO MAKE HEALTH-CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISIONS FOR YOURSELF.

- AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. IN ADDITION, AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

- YOU MAY STATE IN THIS DOCUMENT ANY TYPE OF TREATMENT THAT YOU DO NOT DESIRE AND ANY THAT YOU WANT TO MAKE SURE YOU RECEIVE.

- YOU HAVE THE RIGHT TO TAKE AWAY THE AUTHORITY OF YOUR ATTORNEY IN FACT, UNLESS YOU HAVE BEEN ADJUDICATED INCOMPETENT, BY NOTIFYING YOUR ATTORNEY IN FACT OR HEALTH-CARE PROVIDER EITHER ORALLY OR IN WRITING. SHOULD YOU REVOKE THE AUTHORITY OF YOUR ATTORNEY IN FACT, IT IS ADVISABLE TO REVOKE IN WRITING AND TO PLACE COPIES OF THE REVOCATION WHEREVER THIS DOCUMENT IS LOCATED.

- IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

- YOU SHOULD KEEP A COPY OF THIS DOCUMENT AFTER YOU HAVE SIGNED IT. GIVE A COPY TO THE PERSON YOU NAME AS YOUR ATTORNEY IN FACT. IF YOU ARE IN A HEALTH-CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

POWER OF ATTORNEY FOR HEALTH CARE

I, (your name)_____

(your address)_____

_____

(your telephone number(s)_____

do hereby appoint;
(attorney in fact's name)_____

(attorney in fact's address)_____

_____

(attorney in fact's telephone number(s)_____

as my attorney in fact to act to make health care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person to serve in the order listed below:

A. (successor attorney in fact's name)_____

(successor attorney in fact's address)_____

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

B. (second successor attorney in fact's name)_____

(second successor in fact's address)_____

_____

(second successor attorney in fact's phone number(s)_____

With this document, I intended to create a durable power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below.

STATEMENT OF DIRECTIVES CONCERNING LIFE-PROLONGING CARE, TREATMENT, SERVICES, AND PROCEDURES

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.

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 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

By my signature I indicate that I understand the purpose and effect of this document.

IN WITNESS WHEREOF, I have hereunto signed my name this _____ day of _____, 20____, at (address)_____

_____

_____

Signature of principal

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health-care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the attorney in fact by this document, nor am I the health-care provider of the principal or an employee of the health-care provider of the principal.

Signature of First Witness:_____

Home Address_____

_____

Print Name:_____

Date:_____

Signature of Second Witness:_____

Home Address_____

_____

Print Name:_____

Date:_____

(AT LEAST ONE OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION)

I further declare that I am not related to the principal by blood, marriage, or adoption and, to the best of my knowledge, I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

Signature of First Witness:_____

Signature of Second Witness:_____

Form prepared 2002
Clerical changes made 2008
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