

# **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 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

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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.

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 Minnesota Will to Live Form SUGGESTIONS AND REQUIREMENTS**

1. The document allows you to designate (name) a health care agent or attorney in fact – someone who will make health care decisions for you whenever you are unable to make or communicate them for yourself. It also allows you to give instructions concerning medical treatment decisions that the health care agent must follow. Any adult may designate a health care agent through this document. You can change your agent or alternate agent at any time.
  2. It is helpful to designate a second health care agent to take over if your first choice is unable to serve. There is space on the form for you to designate a successor health care agent. Be sure to inform your agent and alternate agent of their being named and that they may be nominated as guardian or conservator for you.
  3. You must do one of the following to properly designate a health care agent through this document:
    - A) Sign and date this document in the presence of two witnesses, neither of whom is your appointed health care agent or alternate health care agent. At least one witness must not be a health care provider providing direct care to the principal or an employee of a health care provider providing direct care to the principal on the date of execution of this document; OR
    - B) Sign and date this document before a notary public. The notary should not be your appointed health care agent or alternate health care agent.
- NOTE: If you are unable to sign and date the document yourself you may authorize another person to sign on your behalf.
4. According to the Minnesota Durable Power of Attorney for Health Care, a health care declaration – such as this one becomes effective only when you are diagnosed as unable to make or communicate health care decisions. **IN PRACTICE, THEREFORE, THIS DOCUMENT WILL PROBABLY GOVERN HOW YOU ARE TREATED IN ALMOST EVERY CIRCUMSTANCE IN WHICH THE ISSUE OF WHETHER YOU SHOULD GET LIFE SAVING TREATMENT IS LIKELY TO COME UP** and you are then unable to make the decisions yourself.
  5. The document will remain in effect until you revoke (cancel) it. You may revoke this document at any time. Commencement of proceedings for marital dissolution or annulment will revoke naming your spouse as your agent.
  6. You should tell your doctor about this document. You should also ask your doctor to keep a copy of this document as a part of your medical health record.

7. This type of document has been authorized by the Minnesota Durable Power of Attorney for Health Care Act, Minn. Stat. §§ 145C.01 to .16.
8. 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.
9. 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)

Form prepared 2001  
Clerical changes made 01/09  
Reviewed 2013

**STATE OF MINNESOTA  
HEALTH CARE DIRECTIVE  
Will to Live Form**

**PART I: APPOINTMENT OF HEALTH CARE AGENT**

When I am unable to decide or speak for myself, I trust and appoint \_\_\_\_\_  
to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: \_\_\_\_\_

Telephone number of my health care agent: \_\_\_\_\_

Address of my health care agent: \_\_\_\_\_

**APPOINTMENT OF ALTERNATE HEALTH CARE AGENT:** If my health care agent is not  
reasonably available, I trust and appoint \_\_\_\_\_  
to be my health care agent instead.

Relationship of alternate health care agent to me: \_\_\_\_\_

Telephone number of my alternate health care agent: \_\_\_\_\_

Address of my alternate health care agent: \_\_\_\_\_

**PART II: HEALTH CARE INSTRUCTIONS**

These instructions are for my health care when I am unable to decide or speak for myself.  
These instructions must be followed (so long as they address my needs).

**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 agent 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 agent to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my agent, 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 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 agent(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



I understand that I have the right to revoke the appointment of the persons named above to act on my behalf at any time by communicating that decision to the agent or my health care provider.

I hereby revoke all prior designations of agent under other Durable Power of Attorney for Health Care Decision Making I have made in the past.

If the authority granted in this document conflicts with authority I have granted in a Health Care Declaration/Living Will or designation of Proxy for intrusive mental health treatment, the person designated most recently shall control the outcome of that conflict.

If any part of this document is held to be unenforceable under law, I direct that all of the other provisions of this document shall remain in force and effect.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE DEEMED AS VALID AS THE ORIGINAL.

### PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) or witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth \_\_\_\_\_

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

\_\_\_\_\_

If I cannot sign my name, I can ask someone to sign this document for me.

\_\_\_\_\_  
Signature of the person whom I asked to sign this document for me.

\_\_\_\_\_  
Printed name of the person whom I asked to sign this document for me.

OPTION 1: NOTARY PUBLIC

In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

[Notary Stamp]

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

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

OPTION 2: TWO WITNESSES

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

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

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) 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: [    ]

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

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

\_\_\_\_\_

Witness Two:

(i) In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

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

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) 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: [    ]

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

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

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

Form prepared 2001  
Clerical changes made 01/09  
Reviewed 2013