

# **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 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.

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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 in for purposes of these suggestions.

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.**

National Right to Life Committee

[www.nrlc.org](http://www.nrlc.org)

(202) 626-8800

## **How to use the Wyoming Will to Live form--Suggestions and Requirements:**

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1. This document, which is called a "Durable Power of Attorney for Health Care" under Wyoming law, allows you to designate (name) a health care "attorney in fact"--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 attorney in fact must follow. Any adult may designate a health care attorney in fact through this document.
2. You must sign and date the document, and you must also do ONE of the following to properly designate a health care attorney in fact through this document: EITHER
  - (A) You can arrange for two people to witness your signature. Either they must watch you sign the document or you must show them your signature on the document and tell them it is yours. Both witnesses must sign the paragraph on the form immediately under your signature, and one of the witnesses must also sign the following paragraph. (The references in the paragraphs to the "principal" are to you, the person who is making out the Durable Power of Attorney for Health Care.)
  - OR
  - (B) You can swear to and acknowledge the durable power of attorney before a notary public. If you do this, ignore the places for witnesses to sign and give their addresses and telephone numbers. Instead, take the unsigned but otherwise completed document to a notary public, who will direct you to sign it and will fill out the form marked "Notary" at the end of the document.
3. At least one of the witnesses cannot be related to you by blood, marriage, or adoption, and, to the best of his or her knowledge cannot be entitled to receive any part of your estate upon your death under a will (or codicil to a will) now existing or by operation of Wyoming state law. Neither of the witnesses can be:
  - a health care provider,
  - an employee of a health care provider,
  - the attorney in fact,
  - an operator or employee of an operator of a community health care facility, or
  - the operator or employee of an operator of a residential care facility.
4. Your health care attorney must NOT be:
  - your treating health care provider,
  - an employee of your treating health care provider,
  - an operator or employee of an operator of a community care facility or residential care facility.If you name a health care provider who is not now treating you, but who later becomes the health care provider who is treating you, that person will then be unable to serve as your attorney in fact.

There is an exception to these prohibitions. If you wish, you may name as attorney in fact an employee of your treating health care provider, an employee of an operator of a community care facility or an employee of a residential care facility IF the employee is your relative by blood, marriage or adoption.
5. It is helpful to designate successor health care attorney(s) 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 health care attorneys in fact.
6. Your health care attorney in fact will have authority to make health care decisions for you only when you are unable to give informed consent to health care decisions yourself. Despite this document, your attorney in fact may neither authorize nor refuse health care for you if you object.
7. Under Wyoming law, your attorney in fact will not be able to consent to your:

--commitment to or placement in a mental health treatment facility,  
--convulsive treatment,  
or --psychosurgery.

8. Unless you direct otherwise in this document, your attorney in fact will have the same right you would have:
- to receive information about your health care, receive and review your medical records, and consent to disclosure of your medical records,
  - to donate your organs or body for transplant or medical research or training, and
  - otherwise to direct how your remains will be disposed of if you die.

9. Under Wyoming law, THIS DOCUMENT AUTOMATICALLY EXPIRES 7 YEARS AFTER YOU SIGN IT. **Therefore, if you want its provisions to continue, you will need to sign a new durable power of attorney for health care in 7 years.**

However, if at the end of 7 years after you have signed this document you lack the capacity to make health care decisions for yourself, the durable power of attorney for health care will continue in effect until the time when you regain the capacity to make health care decisions for yourself.

10. You may revoke (cancel) this document or the appointment of your attorney in fact at any time when you would have the capacity to sign a durable power of attorney document, such as this one. You may revoke by notifying either your attorney in fact or your health care provider. If you revoke by notifying your health care provider, the provider must note that in your medical records.

If you sign a new document designating a health care attorney in fact, that will revoke this document unless the new document specifically says otherwise.

If this document names your spouse as your attorney in fact, and your marriage ends in divorce or annulment, your ex-spouse will no longer be able to serve as your attorney in fact unless you give different directions in this document. However, if you remarry the same person, she or he will again be eligible to serve as your attorney in fact.

11. 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.

You should also give copies of this document to the people you name as your attorney in fact and successor attorney(s) in fact, family members and close friends. It is also a good idea to carry a copy with you in your wallet or purse at all times, and to attach a note to your medical insurance card, driver's license, or other items hospital admission personnel are likely to look at, asking them to look for it and make it a part of your medical record.

12. 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](http://www.nrlc.org) (click on "Will to Live") or an attorney to determine if this form can still be used.

13. If you have any questions about this document or want assistance filling it out, please consult an attorney.

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For additional copies of the Will to Live, please visit:  
[www.nrlc.org](http://www.nrlc.org) and click on "Will to Live"

Form prepared 2001

Wyoming Durable Power of Attorney for Health Care  
**Will To Live Form**

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

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

designate \_\_\_\_\_ (attorney in fact's name)

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

as my health care attorney in fact to make any health care decisions for me as authorized in this document consistent with the instructions below.

If the person I designate above refuses or is not able to act for me, I designate the following persons (each to act alone and successively, in the order named):

A. \_\_\_\_\_ (successor attorney in fact's name)

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

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

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone \_\_\_\_\_

as my health care attorney in fact to make any health care decisions for me as authorized in this document consistent with the instructions below.

This designation shall become effective only when I become incapable of giving informed consent concerning my own health care decisions.

Any prior designation is revoked.

**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, or 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 above policy, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, 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 conditions.

**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 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 Principal)

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Signature \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

**EITHER**

I declare under the penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as the attorney in fact by this document, and that I am not the health care provider, an employee of a health care provider, the operator of a



community care facility, an employee of an operator of a community care facility, an operator of a residential care facility, nor an employee of an operator of a residential care facility.

First Witness:

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

Print Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

Second Witness:

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

Print Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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

**One** witness must **also** sign the following declaration:

I further declare under penalty of perjury under the laws of Wyoming 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 upon the death of the principal under a will now existing or by operation of law.

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

----- **OR** -----

NOTARY

The State Of Wyoming )

The County of \_\_\_\_\_ )

Subscribed, sworn to, and acknowledged before me by \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public

Date commission expires: \_\_\_\_\_

Form prepared 2001