

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.

Many in the medical profession as well as in the courts are now so committed to the

¹ 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
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How to use the California Will to Live Form SUGGESTIONS AND REQUIREMENTS

1. This form allows you to name a person to make health care decisions for you when you cannot make them yourself and to give instructions about how those decisions should be made. This person, who is called your “agent,” does **not** have to be a lawyer, but normally may not be your treating health care provider, nor an employee of your treating health care provider, nor an operator or an employee of a community health care facility, nor an operator or employee of a residential care facility for the elderly. However, one of these may serve as your agent if the person is related to you by blood, marriage, or adoption and all of the other requirements are satisfied.

Note: You must consult your attorney if you are a “conservatee” under the Lanterman-Petris-Short Act and want to appoint your conservator as your attorney in fact. Your conservator may not serve as your attorney in fact for health care decisions unless you are represented by legal counsel and your lawyer signs a certificate stating in substance: “I am a lawyer authorized to practice law in the state where this power of attorney was executed. I have advised my client concerning his or her rights in connection with this power of attorney and the applicable law and the consequences of signing or not signing this power of attorney, and my client, after being so advised, has executed this power of attorney.”

2. Your agent will **not** have power to authorize your commitment to or placement in a mental health facility, convulsive treatment, psychosurgery, sterilization, or abortion.
3. Your agent may request, review, copy, and receive any information, verbal or written, regarding your physical or mental health, including, but not limited to, your medical and hospital records, and may consent to the disclosure of your medical records. He or she also has the same rights you would have to receive information regarding proposed health care. Your agent also has the power to authorize an autopsy on your body after death, to donate your body or organs and other parts from it for transplantation or other medical or scientific purposes, and to direct how your bodily remains will be disposed of (buried, cremated, or the like).
4. You must sign and date this document. If you cannot sign it yourself, another adult may sign it at your direction and in your presence.
5. You must have either two adult (age 18 or older) witnesses sign the document or the document must be acknowledged before a notary public. The witnesses must meet the requirements listed in the document, and at least one of them must make the additional declaration included on the form.

6. You should carefully read and follow the witnessing procedure described at the end of the form. This document will not be valid unless you either comply with the witnessing procedure or have the document notarized.
7. If you are a patient or resident in a skilled nursing facility, ONE of your witnesses must be a patient advocate or ombudsman named by the State Department of Aging. The patient advocate or ombudsman must sign the witness statement as one of the two witnesses or in addition to notarization. If you have questions about the patient advocate or ombudsman, please consult your facility's administration or an attorney.
8. If a witness does not personally know you, that witness must have convincing evidence of your identity.

However, if you are a patient in a skilled nursing facility, a witness who is a patient advocate or ombudsman may rely upon the representations of the administrators or staff of the skilled nursing facility, or of your family members, as convincing evidence of your identity if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining your identity.
9. Unless you specify a shorter period of time, this document will be effective until you revoke it. You may revoke (cancel) all or part of this document, other than the designation of an agent, at any time and in any manner that communicates your intent to revoke. You may revoke the designation of your agent only by a signed writing or by personally informing the supervising health care provider. If you later sign another durable power of attorney for health care, the later one will revoke this one only to the extent that it is different, unless the later document specifically states otherwise.

Unless this document specifically says otherwise, if it names your spouse as your agent, the dissolution (divorce) or annulment of your marriage will revoke that designation. But if you later remarry your former spouse the designation will go back into effect.
10. 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 or give each of them an executed copy of this document. You may also want to give each of them a signed, dated, and witnessed copy of this document. You may also want to give your doctor an executed copy of this document.
11. This type of document has been authorized by the California Uniform Health Care Decisions Act, California Probate Code Sections 4670 to 4701.
12. 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

Advance Health Care Directive Statutory Form

(California Probate Code Section 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do both of these things. It also lets you express your wishes regarding the designation of your primary physician. You are free to use a different form.

This form is a power of attorney for health care. It lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Except to the extent this form limits the authority of your agent, your agent may make all health care decisions for you, including the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.
- (c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (d) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

This form also lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named.

You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT

I designate the following individual as my agent to make health care decisions for me:

(Name of individual you choose as agent) _____

(Address of agent) _____

(City, State, Zip) _____

(Home phone) _____ (work phone) _____

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent):

(Address of agent) _____

(City, State, Zip) _____

(Home phone) _____ (work phone) _____

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(Name of individual you choose as second alternate agent):

(Address of agent) _____

(City, State, Zip) _____

(ome phone) _____ (work phone) _____

AGENT'S AUTHORITY

My agent is authorized to make all health care decisions for me, subject to the following limitations:

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and agent(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 agent(s) 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 agent(s) 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.):

(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 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 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

(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.

(Add additional sheets if needed.)

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box (), my agent's authority to make health care decisions for me takes effect immediately.

AGENT'S OBLIGATION

My agent shall make health care decisions for me in accordance with this power of attorney for health care. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

AGENT'S POST-DEATH AUTHORITY

My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here:

(Add additional sheets if needed.)

NOMINATION OF CONSERVATOR

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PRIMARY PHYSICIAN
(OPTIONAL)

I designate the following physician as my primary physician:

(Name of physician) _____
(Address) _____
(City, State, Zip) _____
(Home phone) _____ (work phone) _____

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(Name of physician) _____
(Address) _____
(City, State, Zip) _____
(Home phone) _____ (work phone) _____

EFFECT OF COPY

A copy of this form has the same effect as the original.

SIGNATURE

Sign and date the form here:

(Signature) (Date)

(Address, City, State)

(Print Name)

(Note: California law requires that you comply with the witnessing procedure below **OR** obtain acknowledgment by a Notary Public; it is not necessary that you do both. If you choose not to have this document witnessed, you may skip down to the "Acknowledgment" section at the end of this form now, and obtain a notary public's Authentication. **FOR PATIENTS IN A SKILLED NURSING FACILITY: YOU MUST HAVE THIS DOCUMENT WITNESSED BY A PATIENT ADVOCATE OR OMBUDSMAN REGARDLESS OF WHETHER YOU HAVE THIS DOCUMENT WITNESSED OR ACKNOWLEDGED BY A NOTARY PUBLIC.**)

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness Signature: _____

Residence Address: _____

Print Name: _____

Date: _____

Second Witness Signature: _____

Residence Address: _____

Print Name: _____

Date: _____

ADDITIONAL STATEMENT OF WITNESSES

At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her

death under a will now existing or by operation of law.

(signature of witness)

(signature of witness)

SPECIAL WITNESS REQUIREMENT

The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

(Signature)

(Date)

(Address, City, State)

(Print Name)

(Note: Authentication/Acknowledgment is an alternative to the witnessing procedure above; It is not required if you have complied with the witnessing procedure above.)

Authentication by Notary Public [Acknowledgment]

State of California

County of _____

On _____ before me, _____ (here insert name and title of the officer), personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature _____ (Seal)

Form Prepared 2005
Revised 2008