

SUGGESTIONS FOR PREPARING WILL TO LIVE DURABLE POWER OF ATTORNEY

*(Please read the document itself before reading this.
It will help you better understand the suggestions.)*

YOU ARE NOT REQUIRED TO FILL OUT ANY PART OF THIS “WILL TO LIVE” OR ANY OTHER DOCUMENT SUCH AS A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. NO ONE MAY FORCE YOU TO SIGN THIS DOCUMENT OR ANY OTHER OF ITS KIND.

The Will to Live form starts from the principle that the presumption should be for life. If you sign it without writing any “SPECIAL CONDITIONS,” you are giving directions to your health care provider(s) and health care agent¹ to do their best to preserve your life.

Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

If you wish to refuse some specific medical treatment, the Will to Live form provides space to do so (“SPECIAL CONDITIONS”). You may make special conditions for your treatment when your death is imminent, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably terminally ill, meaning you will live no more than three months even if given all available medical treatment. There is also space for you to write down special conditions for circumstances you describe yourself.

The important thing for you to remember if you choose to fill out any part of the “SPECIAL CONDITIONS” sections of the Will to Live is that you must be very specific in listing what treatments you do not want. Some examples of how to be specific will be given shortly, or you may ask your physician what types of treatment might be expected in your specific case.

Why is it important to be specific? Because, given the pro-euthanasia views widespread in society and particularly among many (not all) health care providers, there is great danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

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

Many in the medical profession as well as in the courts are now so committed to the quality of life ethic that they take as a given that patients with severe disabilities are better off dead and would prefer not to receive either life-saving measures or nutrition and hydration. So pervasive is this “consensus” that it is accurate to say that in practice it is no longer true that the “presumption is for life” but rather for death. In other words, instead of assuming that a now incompetent patient would want to receive treatment and care in the absence of clear evidence to the contrary, the assumption has virtually become that since any “reasonable” person would want to exercise a “right to die,” treatment and care should be withheld or withdrawn unless there is evidence to the contrary. The Will to Live is intended to maximize the chance of providing that evidence.

It is important to remember that you are writing a legal document, not holding a conversation, and not writing a moral textbook. The language you or a religious or moral leader might use in discussing what is and is not moral to refuse is, from a legal standpoint, often much too vague. Therefore, it is subject to misunderstanding or deliberate abuse.

The person you appoint as your health care agent may understand general terms in the same way you do. But remember that the person you appoint may die, or become incapacitated, or simply be unavailable when decisions must be made about your health care. If any of these happens, a court might appoint someone else you don’t know in that person’s place. Also remember that since the agent has to follow the instructions you write in this form, a health care provider could try to persuade a court that the agent isn’t really following your wishes. A court could overrule your agent’s insistence on treatment in cases in which the court interprets any vague language you put in your “Will to Live” less protectively than you meant it.

So, for example, do not simply say you don’t want “extraordinary treatment.” Whatever the value of that language in moral discussions, there is so much debate over what it means legally that it could be interpreted very broadly by a doctor or a court. For instance, it might be interpreted to require starving you to death when you have a disability, even if you are in no danger of death if you are fed.

For the same reason, do not use language rejecting treatment which has a phrase like “excessive pain, expense or other excessive burden.” Doctors and courts may have a very different definition of what is “excessive” or a “burden” than you do. Do not use language that rejects treatment that “does not offer a reasonable hope of benefit.” “Benefit” is a legally vague term. If you had a significant disability, a health care provider or court might think you would want no medical treatment at all, since many doctors and judges unfortunately believe there is no “benefit” to life with a severe disability.

What sort of language is specific enough if you wish to write exclusions? Here are some examples of things you might--or might not--want to list under one or more of the “Special Conditions” described on the form. Remember that any of these will prevent treatment ONLY under the circumstances--such as when death is imminent--described in the “Special Condition” you list it under. (The examples are not meant to be all inclusive--just samples of the type of thing you might want to write.)

“Cardiopulmonary resuscitation (CPR).” (If you would like CPR in some but not all circumstances when you are terminally ill, you should try to be still more specific: for example,

you might write “CPR if cardiopulmonary arrest has been caused by my terminal illness or a complication of it.” This would mean that you would still get CPR if, for example, you were the victim of smoke inhalation in a fire.) “Organ transplants.” (Again, you could be still more specific, rejecting, for example, just a “heart transplant.”)

“Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer.”

“A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me.”

Pain Relief

Under the “General Presumption for Life,” of your Will to Live, you will be given medication necessary to control any pain you may have “as long as the medication is not used in order to cause my death.” This means that you may be given pain medication that has the secondary, but unintended, effect of shortening your life. If this is not your wish, you may want to write something like one of the following under the third set of “Special Conditions” (the section for conditions you describe yourself):

“I would like medication to relieve my pain but only to the extent the medication would not seriously threaten to shorten my life.” OR

“I would like medication to relieve my pain but only to the extent it is known, to a reasonable medical certainty, that it will not shorten my life.”

Think carefully about any special conditions you decide to write in your “Will to Live.” You may want to show them to your intended agent and a couple of other people to see if they find them clear and if they mean the same thing to them as they mean to you. Remember that how carefully you write may literally be a matter of life or death--your own.

AFTER WRITING DOWN YOUR SPECIAL CONDITIONS, IF ANY, YOU SHOULD MARK OUT THE REST OF THE BLANK LINES LEFT ON THE FORM FOR THEM (JUST AS YOU DO AFTER WRITING OUT THE AMOUNT ON A CHECK) TO PREVENT ANY DANGER THAT SOMEBODY OTHER THAN YOU COULD WRITE IN SOMETHING ELSE.

IT IS WISE TO REVIEW YOUR WILL TO LIVE PERIODICALLY TO ENSURE THAT IT STILL GIVES THE DIRECTIONS YOU WANT FOLLOWED.

Robert Powell Center for Medical Ethics
National Right to Life
www.nrlc.org ~ (202) 378-8862

How to use the Hawaii Will to Live Form

SUGGESTIONS AND REQUIREMENTS

1. This document allows you to designate (name) 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 health care agent must follow. Any person who is at least 18 years old or emancipated may designate a health care agent through this document.
2. To execute a valid power of attorney, you must sign and date this document, which must be witnessed in one of two ways:
 - A.) Signed by at least two individuals, each of whom witnessed either your signing of the document or your acknowledgment of the signature of the document (if someone signed the document for you in your presence because you were unable to do so); OR
 - B.) Acknowledged before a notary public at any place within this state.
3. A witness cannot be: (1) a health-care provider; (2) an employee of a health-care provider or facility; or (3) the designated agent. At least one of the individuals used as a witness for a power of attorney for health care cannot be: (1) related to you by blood, marriage, or adoption; or (2) entitled to any portion of your estate upon your death under any will or document existing at the time of execution of this document or by operation of law then existing.
4. It is helpful to designate successor health care agent(s) to take over if your first choice is unable to serve. There is space on this form for you to designate two successor agent(s).
5. 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.
6. Your health care agent's authority takes effect only when you no longer have the capacity to make and communicate your own health care decisions.
7. This document will remain in effect until you revoke (cancel) it. You may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider.¹ You may revoke all or part of this health care directive (other than the designation of your agent) at any time in any manner that communicates an intent to revoke. An advance health-care directive that conflicts with an earlier advance health-care directive revokes the earlier directive to the extent of the conflict.

¹ Under State law, though, a decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as your agent, unless the decree specifies otherwise.

8. This type of document has been authorized by the Uniform Health-Care Decisions Act, Hawaii Rev. Stat. §§327E-1 to 327E-16.
9. 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 (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 in filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit www.nrlc.org.

Form prepared 2001
Clerical Changes Made 2008
Reviewed 2015

**Hawaii Power of Attorney for Health Care
Will to Live Form**

DESIGNATION OF AGENT

I, (your name) _____
(your address) _____

(your phone number) _____

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

(Name of agent) _____
(address of agent) _____
(phone number(s) of agent) _____

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

First Successor Agent
(successor agent's name) _____
(successor agent's address) _____

(successor agent's phone number) _____

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

Second Successor Agent
(second successor agent's name) _____
(second successor agent's address) _____

(second successor agent's phone number) _____

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.

My agent's authority to make health-care decisions takes effect immediately.

NOMINATION OF GUARDIAN

In the event a court appoints a guardian on my behalf, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

INSTRUCTIONS FOR HEALTH CARE:

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and my health care 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 my 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 my health care agent to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my health care agent(s) 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 my 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

EFFECT OF COPY

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

Signed this _____ day of _____, 20_____.

(Signature)_____

(Print Name)_____

WITNESSES

This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

FIRST ALTERNATIVE

I declare under penalty of false swearing pursuant to §710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. 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.

First Witness Signature:_____

Date:_____ Address:_____

Print Name:_____

I declare under penalty of false swearing pursuant to §710-1062, Hawaii Revised Statutes, that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

Second Witness Signature: _____

Date: _____ Address: _____

Print Name: _____

**SECOND ALTERNATIVE
NOTARY PUBLIC**

State of Hawaii

County of _____

On this _____ day of _____, 20____, before me (name of notary public) _____, personally known to be (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

Notary Seal

Signature of Notary Public

My commission expires: _____