

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
www.nrlc.org ~ (202) 378-8862

How to use the Oregon Will to Live Form SUGGESTIONS AND REQUIREMENTS

1. This is an important legal document. It can control critical decisions about your health care. Any adult may designate a health care representative through this document. You name a person to direct your health care when you cannot do so. This person is called your “health care representative.” You can do this by using Part B of this form. Your representative must accept on Part E of this form. You can write in this document any restrictions you want on how your representative will make decisions for you. The Will to Live language has been inserted for you. Your representative must follow your desires as stated in this document or otherwise made known. Your representative can resign at any time by giving notice to you (or your health care provider if you are incapable). This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

2. You may sign PART B, PART C, or both parts. **PART C is not recommended.**
NOTE: There are many “INITIAL” requests included in this document that Oregon law requires. Initialing the wrong choice may conflict with the “Will to Live” language contained in PART A paragraph 1. Read these very carefully.

It is recommended that you leave these blank:

INITIAL IF THIS APPLIES:

I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

“Life Support” refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

My representative MAY decide about life support for me. (If you don’t initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

My representative MAY decide about tube feeding for me. (If you don’t initial this space, then your representative MAY NOT decide about tube feeding.)

It is also recommended that you leave Part C: Health Care Instructions unexecuted (unsigned) since execution of this Part may cause confusion in regard to the Will to Live language of Part B. If you choose to execute Part C, however, be sure to read each

“INITIAL” request very carefully. The first responses on numbers 1 through 4 are the most consistent with the Will to Live language. Leave item number 5 blank since items 1 through 4 already address this and item number 5 has great potential for confusion. Be sure to cross out the blank lines for item 6.

3. You must do the following to properly designate a health care representative through this document:

Fill in Part A with the appropriate information.

Part B appoints your representative and an alternate and sets forth the extent of their power in making decisions for you.

- It is recommended that you leave blank and cross out the available lines under the General Presumption for Life so as to avoid any confusion. If you choose to use the available lines, please be as specific as possible.
- Be sure to sign the box under “If I Am Pregnant” if you are a woman of child bearing years.
- Leave the “INITIAL IF THIS APPLIES” item blank **UNLESS you intend to fill out Part C.**
- Leave items 2 and 3 blank also.
- **Date and sign Part B.**

Part C should be left blank. If you choose to execute this Part, however, initial the appropriate statements for item 1 through 4, leaving item 5 blank and crossing out the blank lines for item 6. (See #2 above.) Initial the first statement for item 7. Date and sign.

Part D requires two witnesses to sign and date the document.

1. Sign and date the document, and have two adult witnesses sign it. Each witness must either watch you sign it, or must be told by you that the signature is yours.
2. The witnesses must be adults. At least one witness must not be your relative by blood, marriage or adoption, and must not be a person who at the time of the signing would be entitled to any portion of your estate under your current will or by operation of Oregon state law. Neither witness may be the person you appointed as your health care representative, or your attending physician at the time you make this document.
3. **Each witness must sign the declaration at the end of this document.**

Part E requires those people you wish to designate as your representative and alternate to accept. They must sign and date Part E.

4. Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

5. Your health care representative must be an adult. Your health care representative must not be your attending physician, an employee of your attending physician, or the owner, operator or employee of a health care facility where you are a resident UNLESS the person is related to you by blood, marriage or adoption.
6. It is helpful to designate an alternate health care representative, to take over if your first choice is unable to serve. There is space on the form for you to designate an alternate.
7. Your health care representative's authority takes effect only when you no longer have the capacity to make and communicate your own health care decisions.
8. The document will remain in effect until you revoke (cancel) it. You may revoke this document at any time and in any manner by which you are able to communicate your intent to revoke it, without regard to your mental or physical condition. Revocation is effective upon your informing your attending physician or health care provider, or your representative of the revocation. If you later sign a new Oregon Power of Attorney for Health Care, that will also revoke this one.
9. 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.
10. This type of document has been authorized by Or. Rev. Stat. §§127.505 to -.658.
11. You should periodically review your document to be sure it complies with your wishes. Before making any changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting www.nrlc.org (click on "Will to Live") or an attorney to determine if this form can still be used.
12. If you have any questions about this document or want assistance filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit:
www.nrlc.org and click on "Will to Live"

Form prepared 1998
*clerical revisions made 09/05

Oregon Will to Live Version
Advance Directive
You do not have to fill out and sign this form.

Part A: Important information about this advance directive

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts about Part B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your “health care representative.” You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts about Part C (Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts about Completing this Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that do not express your wishes and add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

(Name) (Birthdate)

(Address)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE

_____ My entire life

_____ Other period (___ Years)

Part B: Appointment of health care representative

I appoint _____ as my health care representative. My representative's address is:

_____ and telephone number is _____.

I appoint _____ as my alternate health care representative.

My alternate's address is _____ and telephone number is _____. I authorize my representative (or alternate) to direct my health care when I cannot do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. Limits.

Special Conditions or Instructions:

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.

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

During the time I am incompetent, my agent, as named below, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

C. OTHER SPECIAL CONDITIONS:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

IF I AM PREGNANT

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care 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.

<p>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.</p>
<p>_____ Signature of Principal</p>

INITIAL IF THIS APPLIES:

____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

“Life support” refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

(Signature of person making appointment)

(Date)

Part C: Health Care Instructions

NOTE: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in Part B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:

- _____ I want to receive tube feeding.
- _____ I want tube feeding only as my physician recommends.
- _____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

- _____ I want any other life support that may apply.
- _____ I want life support only as my physician recommends.
- _____ I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

5. General Instruction.

INITIAL IF THIS APPLIES:

I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions.

(Insert description of what you want done.)

7. Other documents. A “health care power of attorney” is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

- _____ I have previously signed a health care power of attorney.
I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.
- _____ I have a health care power of attorney, and I REVOKE IT.
- _____ I DO NOT HAVE a health care power of attorney.

SIGN HERE TO GIVE INSTRUCTIONS

(Signature)

(Date)

Part D: Declaration of Witnesses

We declare that the person signing this advance directive:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed or acknowledged that person’s signature on this advance directive in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Has not appointed either of us as a health care representative or alternative representative; and
- (e) Is not a patient for whom either of us is an attending physician.

Witnessed By:

(Signature of Witness/Date)

(Printed Name of Witness)

(Signature of Witness/Date)

(Printed Name of Witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

Part E: Acceptance by Health Care Representative

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

(Signature of Health Care Representative/Date)

(Printed Name)

(Signature of Alternate Health Care Representative/Date)

(Printed name)