

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 South Carolina Will to Live Form SUGGESTIONS AND REQUIREMENTS

1. This document allows you to designate (name) a health care attorney in fact 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.
2. To properly designate a health care agent through this document, you must sign and date this document, two witnesses must sign it, and it must be acknowledged before a notary public. (If you are unable to sign and date the document yourself, you may direct someone to do it for you in your presence.) Each of the two witnesses must EITHER witness the actual signing of the document by you or at your direction OR be told by you that the signature was by you or at your direction.
3. It is helpful to designate successor health care agents, 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 agents.
4. Section 62-5-501(B) of the South Carolina Code states that unless this document whose legal name is a “power of attorney,” provides otherwise, a court may still appoint a guardian or conservator, who would have authority to make health care decisions for you when you cannot make them for yourself. If the court appoints a guardian or conservator, the law says that appointment ends “all or part of the power of attorney that relates to matters within the scope” of the guardian or conservator’s authority. Therefore, in order to protect your ability through this document to have your own directions followed and your own choice of a health care agent protected, the document directs that a court NOT make an appointment that would end all or part of the authority of this document.
5. Your health care agent’s authority takes effect only when you no longer have the capacity to make your own health care decisions.
6. The document will remain in effect until you revoke (cancel) it. You may revoke this document (in whole or in part) or limit your health care agent’s authority at any time. You should be careful to notify your agent of the revocation, preferably in writing.
7. 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.
8. This type of document has been authorized by the South Carolina Powers of Attorney Act, S.C. Code Ann. §§ 62-5-501 to -504.

9. 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 any attorney to determine if this form can still be used.
10. 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.

Form prepared 2005
Updated 06/11
Reviewed 2013

South Carolina Will to Live Form

Information About This Document

This is an important legal document. Before signing this document, you should know these important facts:

1. This document gives the person you name as your agent the power to make health care decisions for you if you cannot make the decision for yourself. This power includes the power to make decisions about life-sustaining treatment. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have.
2. This power is subject to any limitations or statements of your desires that you include in this document. You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent will be obliged to follow your instructions when making decisions on your behalf. You may attach additional pages if you need more space to complete the statement.
3. After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. After you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.
4. You have the right to revoke this document, and terminate your agent's authority, by informing either your agent or your health care provider orally or in writing.
5. If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or another person to explain it to you.
6. This power of attorney will not be valid unless two persons sign as witnesses. Each of these persons must either witness your signing of the power of attorney or witness your acknowledgment that the signature on the power of attorney is yours.

The following persons may not act as witnesses.

- A. Your spouse; your children, grandchildren, and other lineal descendants; your parents, grandparents, and other lineal ancestors; your siblings and their lineal descendants; or a spouse of any of these persons.
- B. A person who is directly financially responsible for your medical care.

- C. A person who is named in your will, or, if you have no will, who would inherit your property by intestate succession.
- D. A beneficiary of a life insurance policy on your life.
- E. The persons named in the health care power of attorney as your agent or successor agent.
- F. Your physician or an employee of your physician.
- G. Any person who would have a claim against any portion of your estate (person to whom you owe money).

If you are a patient in a health facility, no more than one witness may be an employee of that facility.

- 7. Your agent must be a person who is 18 years old or older and of sound mind. It may not be your doctor or any other health care provider that is now providing you with treatment; or an employee of your doctor or provider; or a spouse of the doctor, provider, or employee; unless the person is a relative of yours.
- 8. You should inform the person that you want him or her to be your health agent. You should discuss this document with your agent and your physician and give each a signed copy. If you are in a health care facility or a nursing care facility, a copy of this document should be included in your medical records.

HEALTH CARE POWER OF ATTORNEY
(S.C. STATUTORY FORM)

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint _____
(principal) (agent)

(Address)

Home Telephone: _____

Work Telephone: _____

as my agent to make health care decisions for me as authorized in this document.

SUCCESSOR AGENT: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successor to my agent, each to act alone and successively, in the order named.

A. First Alternate Agent: _____
Address: _____
Telephone: _____

B. Second Alternate Agent: _____
Address: _____
Telephone: _____

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

3. HIPAA AUTHORIZATION

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not

limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

4. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document.

The powers granted above are subject to the following limitations:

GENERAL PRESUMPTION FOR LIFE

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

D. IF I AM PREGNANT

Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care agent(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

<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 style="text-align: right;">_____ Signature</p>
--

5. ORGAN DONATION (INITIAL ONLY ONE)

My agent may _____; may not _____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

Any prior designation of a health care agent and any prior declarations under the South Carolina Death with Dignity Act or other expressions of my wishes inconsistent with this document are revoked.

7. ADMINISTRATIVE PROVISIONS

- A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.
- B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

8. UNAVAILABILITY OF AGENT

If at any relevant time the Agent or Successor Agents named herein are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document. In light of S.C. Code Ann. § 62-5-501(B), I state my intention that I do NOT wish a court to appoint a guardian or conservator whose appointment would terminate all or part of the authority of this power of attorney.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this _____ day of _____,

_____.

My current home address is:

Signature: _____

Name: _____

WITNESS STATEMENT

I declare on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

First Witness

Signature: _____

Date: _____

Print Name: _____

Telephone: _____

Residence Address: _____

Witness No. 2

Signature: _____

Date: _____

Print Name: _____

Telephone: _____

Residence Address: _____

NOTARIZATION

In the State of _____, City/County of _____,
Subscribed and sworn before me, the undersigned Notary Public in and for the city/county
aforesaid this _____ day of _____, _____. My commission expires the
_____ day of _____, _____.

Affix official seal here

(Signature of Notary Public)