Advanced Directives

Advance Planning: What Everyone Needs to Know

A time may come when an accident or illness, short-term or permanent, will prevent you from making and communicating your own medical-care decisions. ***Advance planning*** is an action you can take while you are well. ***Advanced planning*** can help ensure that your wishes will be followed if you can't speak for yourself. Advanced planning can take any three forms:

·A living will ·A durable power of attorney ·Written or spoken instructions to family, friend, and a doctor

Why do you need advance Planning?

Technology advances have enabled doctors to save lives and improve the quality of life. Sometimes, however, technology prolongs life where there is no hope for recovery. It is then when a decision must be made about whether to use life-support and for how long. **Advance planning** helps ensure that your wishes about the use of life support will be honored.

People have started to hear the terms **"living wills," durable power of attorney for health care," and "advanced directives."** Their use in the media has increased since the U.S. Supreme Court decision in the Nancy Cruzan case. In that case, treatment was continued despite family objections because there was no clear proof of Ms. Cruzan's wishes.

Another reason the terms are heard so often is that the federal government has recently passed the Patient Self Determination Act. This ruling requires medical-care facilities to inform patients of their rights, under state law, to accept or reject treatment and to make their wishes known in advance.

Advance planning methods

Living wills and **durable powers of attorney for medical care** are formal, legally binding methods for stating your wishes about future treatment. They are called **Advance Directives.**

A **living will** lets you make a formal written statement about future medical care under various circumstances. **Living wills** are often applied only in terminal-care situations. (The definitions of "terminal" vary from state to state.)

A **durable power of attorney for medical care** lets you appoint someone to act on your behalf if you cannot speak for yourself. You actually give a family member or friend (who is at least 18 years of age) the authority to act as a patent advocate and make sure your instructions are followed.

Laws for formal **advanced directives** (especially **living wills**) vary greatly from state to state as to format, methods of implementation and to what medical conditions the document applies.

Living Will

To My Family, My Physician, My Clergyman & My Substitute Decision Maker in the Durable Power of Attorney:

I, _____, being of sound mind, make this statement as an indication of my choice of medical care and as a directive to be followed if I become unable to participate in decisions regarding my health care. These instructions reflect my commitment to decline medical treatment under circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only to prolong the process of my dying if I should be in incurable or irreversible physical condition with no reasonable expectation of recovery.

These instructions apply if I am: (a) in a terminal condition; or (b) permanently unconscious; or (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct the treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

If I am in any one of the conditions described above, I have indicated my wishes in regard to the following forms of treatment:

Cardiac Resuscitation	☐ **I do want**	☐ **I do not want**
Mechanical Respiration	☐ **I do want**	☐ **I do not want**
Feeding Tubes	☐ **I do want**	☐ **I do not want**
Kidney Dialysis	☐ **I do want**	☐ **I do not want**
Chemotherapy	☐ **I do want**	☐ **I do not want**
Antibiotics	☐ **I do want**	☐ **do not want**
Intravenous Fluids	☐ **I do want**	☐ **I do not want**

Additional Instruction: _____
_____

These directives express my right to refuse treatment and they are my instructions to my substitute decision maker as constituted in the Durable Power of Attorney instrument. I intend that my instructions be carried out unless I have rescinded them in a new written declaration by a clear oral expression that I have changed my mind.

By signing this form, I hereby consent to this discussion with my physician/provider.

_____ _____/_____/_____
Signature Date

_____ _____/_____/_____
Physician/Provider Date

My designated decision maker is: _____
Whose current address and phone number is: _____

The standard operating procedures of most health care facilities assume that you would want life sustaining procedures provided unless you indicate otherwise.

Durable Power of Attorney for Health Care

I, _____ of _____, Michigan,
(Name) (City)
hereby appoint _____,
(Durable Power of attorney for health care/Patient Advocate)
As my attorney in fact (herein called patient advocate) with the following power to be exercised in my name and for my benefit, including, but not limited to, making decisions regarding my care, custody or medical treatment. This power of attorney has effect only if I become unable to participate in medical treatment decisions.

If the first individual is unable, unwilling or unavailable to serve as my patient advocate, then:
I designate: _____ residing at
(Successor Advocate Address)
_____. To serve as my patient advocate. With respect to my personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

(If any of the following do not apply, I may cross them out and place my initials next to the cross out.)

A. To have access to and control over my medical and other personal information.
B. To employ and discharge physicians, nurses, therapists and other care providers, and to pay them reasonable compensation.
C. To give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments such as artificial nutrition and hydration.
D. To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care which I may need, or to discontinue care that I am receiving.
E. Decisions that could or would allow my death (except if I am pregnant.)

My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. Some of those preferences may be recorded below:
(Recording any of your preferences is OPTIONAL.)

My wishes concerning care are as follows: _____
_____
_____
_____

It is my intent that my family, the medical facility, and my doctors, nurses and other medical personnel involved in my care not be liable for implementing the decisions of my patient advocate or honoring wishes expressed in this designation.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document. This document is to be treated as a Durable Power of Attorney and shall survive my disability or incapacity.

This document is signed in the state of Michigan. It is my intent that the laws of the state of Michigan govern all questions concerning its validity, the construction of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

Durable Power of Attorney Health Care (continued)

I voluntarily sign this Durable Power of Attorney after careful consideration. I understand its meaning and accept its consequences.

_____ _____/_____/_____
Signature Date

_____ _____-_____-_____
Printed Name Social Security Number

Witnesses:

(A witness shall not sign this Durable Power of Attorney unless the person appears to be of sound mind and under no duress, fraud, or under influence.)

_____ _____
Witness 1 Signature Street Address

_____ _____
Printed Name City, State, Zip Code

_____
Phone Number

_____ _____
Witness 2 Signature Street Address

_____ _____
Printed Name City, State, Zip Code

_____
Phone Number

(A witness must be a disinterested individual and may not be the person's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, and employee of a life or health insurance provider for the patient, an employee of a health facility that is treating the patient, or an employee of a home-for-the-aged.)