PROTECTIVE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Note: This document has been adapted from the Wisconsin Protective Power of Attorney for Health Care (PPAHC), which is prepared by and available from Pro-Life Wisconsin. (For Wisconsin residents only, the Wisconsin-specific PPAHC is available for FREE download in PDF format at www.prolifewisconsin.org.)

Pro-Life Wisconsin (PLW) has granted permission for the Pro-life Healthcare Alliance (PHA), a program of Human Life Alliance (HLA), to model the Protective Durable Power of Attorney for Health Care after the Wisconsin PPAHC.

The Protective Durable Power of Attorney for Health Care (PDPAHC) is designed for use in an emergency situation. Due to numerous calls from people seeking immediate help to obtain and complete a pro-life durable power of attorney for health care in emergency situations, the PHA/HLA recognized a need for a document that could be quickly downloaded. The PDPAHC is readily available when a person, who has not previously completed a durable power of attorney for health care, is about to undergo emergency surgery, has been seriously injured, etc.

The PDPAHC is a valid advance directive in states that do not have specific state requirements for advance directives.

The PDPAHC is for use in an emergency only in those states which have unique state requirements for a valid durable power of attorney for health care. When you use the PDPAHC in an emergency, replace it as soon as possible with a state-specific form if you reside in any of the following states: Alabama, Alaska, California, Connecticut, Delaware, Florida, Hawaii, Indiana, Kentucky, Maryland, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New York, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Texas, Vermont, West Virginia, or Wisconsin.

The document the PHA/HLA recommends for residents of these states (with the exception of Wisconsin) is the state-specific Protective Medical Decisions Document (PMDD) distributed by the Patients Rights Council. To order, call 1-800-958-5678. This document is not available online for download. The PHA/HLA strongly advises everyone who is 18 years old or older or an emancipated minor to order your PMDD immediately and complete it before you need it.

THESE MATERIALS ARE NOT LEGAL ADVICE. IT IS NOT REQUIRED, BUT YOU MAY WISH TO SEEK THE ASSISTANCE OR ADVICE OF AN ATTORNEY.
QUESTION AND ANSWERS ABOUT THE PROTECTIVE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

What is the Protective Durable Power of Attorney for Health Care (PDPAHC)?

The PDPAHC is a document that enables you, a person who fully respects human life, to appoint someone you trust to make health care decisions for you, in accord with sound moral principles and your express wishes, in the event you become permanently or temporarily incapable of speaking for yourself.

Is the PDPAHC preferable to a Living Will?

Yes, definitely. By executing a PDPAHC you ensure that the person with authority to make medical decisions for you is a carefully chosen family member or friend, familiar with your principles and wishes and capable of firmly protecting your best interests.

A Living Will, on the other hand, is an advance directive in which a person gives health care providers authority to withhold, withdraw or provide medical treatment and even ordinary care, such as tube-feeding, in future, unforeseeable circumstances. This is dangerous. Medical decisions should always be based on current information. (See “Principles for Making Moral Medical Decisions,” page 3.)

Should I name more than one agent?

It is not required, but it is advisable to name an alternate agent in case your primary agent is unavailable or becomes incapacitated.

Should I periodically renew and/or review my PDPAHC?

Your PDPAHC is permanent, unless revoked by you in the presence of two witnesses. You should discuss your wishes in detail with your agent when you sign your PDPAHC (or state-specific PMDD) and periodically review it with your agent.

To whom should I give originally signed copies of my PDPAHC?

You should give completed, witnessed, and originally signed documents to your agent(s) and to your primary care physician. Also, keep one for yourself in a readily accessible place, along with a record of each person to whom you have give a copy. If you ever change or revoke your document, this record will be helpful.

How do I revoke a previously signed advance directive?

By completing the PDPAHC, you revoke any prior advance directive. It is wise to retrieve and destroy all copies of previously executed directives.
Principles for Making Moral Medical Decisions

By Julie Grimstad

1. No matter what life-sustaining procedure/medical treatment is in question, when in doubt, **err on the side of life**. You can always try an intervention with the option of stopping it if it proves ineffective or excessively burdensome for the patient.

2. It is the physician’s obligation to truthfully and fully, in layperson’s terms, discuss with the patient/agent/family/guardian the benefits, risks, cost, etc. of all available medical means that may improve the patient’s condition or prolong life. The focus should be on what the person making medical decisions needs to know in order to give truly informed consent.

3. The patient/agent makes the decision whether or not a particular treatment is too burdensome. If the patient wishes to fight for every last moment of life, it is his/her right to receive/continue treatment and care that might extend life.

4. It is impossible to make morally sound, sensible, informed health care decisions based on guesswork about some future illness or injury/treatment options. Health care decisions must be based on current information.

5. Two extremes are to be avoided:
   - Insistence on useless or excessively burdensome treatment even when a patient may legitimately wish to forgo it.
   - Withdrawal or withholding of treatment with the intention to cause death.

6. The object and motive for administering pain medication must be to relieve pain; death must not be sought or intended.

7. Nutrition and hydration, whether a person is fed with a spoon or through a tube, is basic care, not medical treatment. Insertion or surgical implantation of a feeding tube takes medical expertise, but it is an ordinary life-preserving procedure for a person who has a working digestive system but is unable to eat by mouth. Circumstances and intent determine the morality of withholding food and fluids.
   - **Acceptable** - During the natural dying process, when a person’s organs are shutting down so that the body is no longer able to assimilate food and water or when their administration causes serious complications, stopping tube-feeding or spoon-feeding is both medically and morally appropriate. In these circumstances, the cause of death is the person’s disease or injury, not deliberate dehydration.
   - **Unacceptable** - When a person is not dying—or not dying quickly enough to suit someone—food and fluids are often withheld with the intent to cause death because the person is viewed as having an unacceptably low quality of life and/or as imposing burdens on others.
PROTECTIVE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Document made this ________ day of______________________, _____________
(date)                          (month)                         (year)

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a durable power of attorney for health care in which I appoint a health care agent (attorney-in-fact) for the purpose of making health care decisions for me in the event I am unable to make health care decisions for myself due to incapacity and only for the duration of such incapacity.
DESIGNATION OF HEALTH CARE AGENT(S)
(Print the information in this section.)

I,

Name: _______________________________________________________________________

Address: _____________________________________________________________________

Date of birth: ____________________________

do hereby designate

Name: _______________________________________________________________________

Address: _____________________________________________________________________

Telephone: _______________________________

to be my health care agent (attorney-in-fact).

If he/she is ever unable or unwilling to be my health care agent, I hereby designate

Name: _______________________________________________________________________

Address: _____________________________________________________________________

Telephone: _______________________________

to be my alternate health care agent (attorney-in-fact).

GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to the directions and limitations in this document, I hereby grant my agent full authority
to make health care decisions for me if I am unable to receive and evaluate information
effectively or to communicate decisions to such an extent that I lack the capacity to manage my
health care decisions. I expect to be fully informed about and allowed to participate in any
health care decisions for me to the extent that I am able.

Nothing in this document shall authorize anyone to approve or commit any action or
omission which will cause my death. While certain forms of care and treatment may be futile
in curing a disease or injury, care or treatment which sustains life is not futile. I reject both
euthanasia and assisted suicide, which are contrary to my belief that human bodily life is
inherently good and not merely instrumental to other goods.
DIRECTIONS AND LIMITATIONS

I have discussed my beliefs, principles, and health care preferences with my agent. I trust my agent to make health care decisions for me based on my desires as stated in this document or which I have otherwise expressed to my agent.

1. I have discussed the meaning of the words used in this document with my agent and my agent’s interpretation of them is controlling. “Benefit” refers to my physical health, comfort, and longevity and shall not be determined by quality of life judgments. I **direct that nothing in this document be interpreted to request or authorize providing, withholding, or withdrawing treatment or care for the purpose of causing my death.**

2. My agent has the authority to request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records, and to consent to the disclosure of this information.

3. I direct that nutrition and hydration, administered either orally or by artificial means, be provided to me unless I am unable to assimilate food and fluids, their administration causes serious complications, or my death is inevitable within days or hours from a cause independent of nutrition and hydration.

4. I direct my agent to request, require, and consent to care, treatment, and procedures which are appropriate to my condition/offer hope of benefit.

5. I direct my agent to refuse care, treatment, and procedures which are not appropriate to my condition/do not offer hope of benefit.

6. I direct that my agent, not a health care provider, determine whether or not a Do Not Resuscitate (DNR) order is appropriate for me.

7. I authorize my agent to admit me to or discharge me from a long-term care facility or other residential or community-based care facility.

8. If I am pregnant, I direct that every effort be made to save the life of my child.

9. I direct my agent to firmly protect my rights and best interests, taking legal action if necessary.

10. My agent shall not be held personally liable for any costs for taking legal action or for medical goods or services purchased or contracted for in compliance with my wishes regarding medical care and treatment, except as required by law.
11. It is my express wish that no one petition the court to remove or replace my agent unless it can clearly be shown that my agent has failed or refused to act in accord with these directions, special provisions, and limitations.

These instructions are always a part of my Protective Durable Power of Attorney for Health Care document and are binding on my agent and health care providers.

This document is intended to be valid in any jurisdiction in which it is presented. Any invalid provision of this document shall not affect any other provision of this document or the appointment of my agent.

IMMUNITIES

My agent may not be held criminally or civilly liable for making decisions in accord with this document. No health care facility or provider may be held criminally or civilly liable for following the directions of my agent acting in accord with this document.

REVOCATION OF PREVIOUSLY SIGNED HEALTH CARE DIRECTIVES

By signing this durable power of attorney for health care, I revoke any prior health care directives I have made. This power of attorney shall remain in force until revoked by me in the presence of two witnesses. Additionally, if I, or anyone else on my behalf, execute a health care directive at a later date and I have not revoked this power of attorney, I direct that this power of attorney take precedence.

GUARDIAN OR CONSERVATOR

If it becomes necessary to appoint a guardian or conservator of the person for me, I nominate, in the same order of preference, my agent and alternate agent.

SIGNATURE OF PRINCIPAL

I, being of sound mind, intend this document to create a durable power of attorney for health care. I am executing this document voluntarily.

Signature_________________________________________Date_________________
WITNESSES

I am at least 18 years of age. I am not the person appointed as an agent in this document.

I declare under penalty of perjury that the person who signed or acknowledged this durable power of attorney for health care is personally known to me and I believe he/she is of sound mind and at least 18 years of age or an emancipated minor. He/she signed or acknowledged this document in my presence and did not appear to be under duress or undue influence.

I am not the signer’s health care provider, the owner or operator of the health care facility (including the hospital or long-term care or other residential or community care facility) which is serving the signer, or an employee or agent of the signer’s health care provider or facility.

I am not financially responsible for the signer’s care nor am I an employee or agent of his/her life insurance or health insurance provider.

I am not related to the signer by blood, marriage, or adoption. To the best of my knowledge, I am not entitled to and do not have a claim on his/her estate.

Witness No. 1:

(print) Name_______________________________________Date__________________

(print) Address___________________________________________________________

Signature_______________________________________

Witness No. 2:

(print) Name_______________________________________Date__________________

(print) Address___________________________________________________________

Signature_________________________________________________________