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Termination of Treatment of Adults

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**CENTER FOR BIOETHICS
UNIVERSITY OF MINNESOTA**

**READING PACKET ON
TERMINATION OF TREATMENT
OF ADULTS**

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OVERVIEW OF TERMINATION OF TREATMENT FOR ADULTS*

Advances in medical technology have dramatically increased our ability to control the circumstances and timing of death. With techniques such as dialysis, mechanical ventilation, artificial nutrition and hydration, and cardiopulmonary resuscitation (CPR), we can now prolong the lives of patients who would otherwise certainly die. But this newfound power also raises questions about whether, or under what circumstances, medical interventions should cease and a patient be allowed to die. Concurrent with these technical advances, we have come increasingly to regard the patient as the ultimate authority in decisions about whether to use or forego medical treatment. A complex set of issues surrounding decisions to terminate medical treatment has thus taken shape within the context of our new ability to forestall death and the individual patient's assuming a central role in medical decision-making. Although discussion of these issues has often been framed in terms of withholding or withdrawing life-sustaining treatment from the terminally ill, it is helpful – and more accurate in light of over 20 years of court decisions – to set aside these terms and focus simply on "termination of treatment".

In our technologically advanced society, relatively few people meet their deaths in the traditional setting – in their own homes, surrounded by family members and close friends. Most Americans now die in a hospital or a long-term care facility, and the vast majority of these deaths occur after a decision has been made to forgo or to terminate at least some medical interventions which might have prolonged their lives.¹ How decisions about the termination of treatment are reached, and whose values and interests are served by such decisions, should therefore be of profound concern for each of us.

Ethical Values

Decisions about the termination of treatment require careful consideration of the relative importance of a number of distinct ethical values. The most prominent of these are: (1) individual autonomy; (2) beneficence (i.e., promoting the patient's well-being); (3) the integrity of the medical

profession; and (4) justice or equity.² Within this ethical framework, individual autonomy is generally identified as the central value which should guide termination of treatment decisions.³ In addition, there are other important social, ethical and religious values which are relevant to termination of treatment decisions. Most important of these is the value of the preservation of life, which usually is understood to create a presumption in favor of continued treatment. This presumption can, however, be overridden when it comes into conflict with an individual's choice.

The Right to Refuse Treatment

The principal way in which patients exercise autonomy or self-determination in health care decisions is by giving their informed consent or refusal to proposed medical treatments.⁴ To make an informed decision, a patient must have the opportunity to consider the diagnosis, prognosis, and anticipated benefits and risks of the proposed treatment as well as alternatives, including the option of non-treatment. This information should be provided by appropriate health care professionals, and should be presented in an understandable manner which permits patients to relate it to their own personal values and goals. We demonstrate our respect for human dignity when we acknowledge the freedom of patients to make choices in accordance with their own values.⁵ The emphasis placed on patients' personal values and goals means that we should not consider only narrow medical values or health concerns. For example, many seriously ill patients find that their care imposes significant burdens on family members who must assist in providing necessary care, and may seriously deplete their families' savings. In such circumstances, patients may prefer to receive only comfort care, and forgo life-sustaining treatments that they believe will prolong their families' obligations.⁶

A patient's right to refuse treatment is grounded in both the common-law right to be free from unwanted bodily invasion and the constitutional right to liberty. The right to refuse treatment is thus very broad – any patient with decision-making capacity can refuse any proposed medical treatment – and is limited only by four potentially compelling state interests: (1) the preservation of life; (2) the prevention of suicide; (3) the protection of third parties; and (4) the protection of the ethical integrity of the health care

professions.⁷ Only rarely, however, have the courts found that the state's interests "trump" the patient's decision.

Notions of rights and duties are often seen as correlative. Given that we acknowledge a right to refuse treatment knowing that death will result, the question arises whether there might be a duty in some circumstances to refuse life-prolonging treatments, in a short, a duty to die.⁸ The question whether there is a duty to die was initially raised in the context of discussions about how to bring the spiraling costs of health care under control,⁹ and economic concerns remain at the center of the debate. Some argue that the financial burdens which must be borne by families or the broader society in order to provide life-sustaining treatment to patients, especially the elderly, who would otherwise die simply are not counterbalanced by the benefits of prolonging the lives of these patients. Others respond that it would be wrong to let economic concerns override the traditional presumption in favor of preserving life. We see, then, that the advocates of a duty to die generally do not appeal to the value of respect for individual autonomy to support their position. Rather, they look toward broader communitarian values and the impact of treatment decisions on the patient's family and friends, as well as the costs to society as a whole. The tension between these outlooks may be irresolvable. On the one hand, advocates of individual autonomy must guard against a complete disregard of the social context in which decisions are reached; on the other, those who profess communitarian values must guard against the dangers of coercion and disregard for the unique values of individual patients.

The Problem of Futility

Many discussions of ethical issues surrounding termination of treatment decisions have focused on the right of patients and their families to refuse treatments offered by medical professionals. Equally difficult problems arise when physicians are unwilling to provide treatments desired by patients or their families who feel very strongly that "everything possible" should be done to prevent death. Physicians may believe that preserving the integrity of the medical profession requires them to terminate treatments that hold little chance of improving the medical condition of their patients.¹⁰ We must acknowledge that respect for patient autonomy is subject to certain limits, and

does not imply an absolute right to receive every demanded treatment. But this does not tell us what obligations health care providers have when there is a request for treatment that they believe to be futile.

There is an ongoing debate in the ethics literature about futility. The concept of medical futility has proven very difficult to define. Ambiguity is fostered by the use of the term to refer to both quantitative and qualitative components.¹¹ A range of definitions have been proposed, from physiologically futile for the patient to not worthwhile to society.¹² Those who question the use of futility judgments to limit the treatment options presented to patients often argue that what effects are deemed desirable or beneficial may depend on whether the patient's or the clinician's perspective is adopted. They express concern that assertions of futility may camouflage judgments about the comparative worth of patients' lives.¹³ Others emphasize that patient authority must be tempered by recognition of the actual probability that a treatment will produce its intended effect.¹⁴ It must be acknowledged, however, that even seemingly objective claims about the likelihood that an intervention will produce some effect are tinged with uncertainty, and for some patients, a vanishingly small probability of success will be viewed as preferable to foregoing the treatment.

The problem of futile treatment confronts us with the difficult task of disentangling the roles of "facts" and "values" in medical decision-making.¹⁵ There is as yet no consensus about how to resolve these questions, and clinicians must approach them with both caution and sensitivity. This will be especially important as we enter an era of health care reform in which questions of resource allocation and cost control assume prominence, and health care providers confront incentives to limit the amount and type of treatment available to their patients. The magnitude of this problem is illustrated by debates about the futility of CPR for patients in different age and disease categories and those unlikely to survive to hospital discharge, since resuscitation efforts are almost always attempted unless there is a do-not-resuscitate (DNR) order for the patient.¹⁶

Assessing Decision-Making Capacity

Adult individuals are presumed to have decisional capacity unless they are shown to lack it. Such capacity is important since a valid informed consent or refusal should be the result of reasoned deliberation about the benefits and burdens of available alternatives in light of the patient's values and goals. Although many discussions use the terms 'incompetence' and 'decision-making incapacity' interchangeably, the former is associated with a legal determination that the patient fails to meet the legal standard for "soundness of mind" – a much broader notion than is required in the context of termination of treatment decisions.¹⁷ Here we are concerned with the patient's much more narrowly defined ability to make a particular health care decision, as assessed in clinical settings by health professionals.

In assessing a patient's decision-making capacity, construed in this narrow sense, the clinician should consider whether the patient understands the diagnosis, the various prognoses with the proposed treatment or the alternatives, and the likely consequences of consenting to or refusing any of the treatment options. A patient should not be determined to lack decision-making capacity solely on the basis of a choice different from that which the physician or others would make.¹⁸ It is important to recognize that patients may have religious and cultural values quite different from those of their caregivers, and to guard against this source of bias in assessing their decision-making capacity. Respecting autonomy means that people are free to make decisions others think are foolish as long as their choices result from consideration of the available alternatives and are consistent with their personal values.

Another, perhaps more subtle, form of bias in assessing decision-making capacity may arise from our culture's view of gender-based differences. In a review of court cases addressing the right to terminate treatment, evidence of gender bias was found in judicial interpretations of patients' or their family members' statements about treatment preferences.¹⁹ Of particular concern is the courts' systematic devaluation of women's opinions as unreflective, emotional, or immature, with the implicit suggestion that they lack true decision-making capacity. Other biases, for example on the basis of age, should also be guarded against.²⁰

Standards for Decisions

A determination that a patient lacks decision-making capacity does not erase the patient's substantive right to refuse treatment. However, since the patient is not able to make a choice for him or herself, the procedure for exercising that right is significantly different.

For purposes of medical decision-making, all patients belong to one of four categories: (1) patients with decision-making capacity; (2) patients who previously had such capacity and have expressed their wishes regarding medical care or their choice of a proxy decision-maker, or both; (3) patients who previously had such capacity but did not express their wishes; and (4) patients who never had decision-making capacity.

This classification reflects the importance our society attaches to the capacity to make autonomous choices and to communicate those choices to others. Respect for patients' autonomy requires that, insofar as possible, termination of treatment decisions should be guided by their expressed wishes regarding medical care. For patients in category (1), respecting autonomy means that we should honor the patient's informed consent or refusal regarding treatment.

Matters are more complicated with patients in the other categories since they lack the ability to contemporaneously articulate decisions regarding their present circumstances. Many of the most difficult termination of treatment decisions involve patients who are permanently unconscious, but capable of prolonged survival.²¹ A consensus has emerged, however, that there is a hierarchy of standards which should guide those making treatment decisions for patients in categories (2) – (4) who are incapable of active participation in the decision-making process.²² In descending order of preference, these standards are:

- (i) A subjective standard, requiring that any explicit oral or written instructions about treatment preferences given by the patient before losing decision-making capacity should guide treatment decisions. If the patient designated a proxy decision-maker, that designation should also be honored.
- (ii) If there are no such instructions, a substituted judgment standard, which requires that an attempt be made to determine what the patient would

have wanted in the present situation, based on knowledge of the patient's prior preferences and personal value system.

- (iii) If there are no explicit instructions and there is insufficient information on which to base a substituted judgment, a best interests standard, according to which the surrogate decision-maker is guided not by the patient's preferences (which are unknown) but by the patient's interests, where these are understood to be objective.²³

Patients whose prior preferences regarding medical treatment were not stated in clear and explicit terms are perhaps the most vulnerable to abuse in termination of treatment decisions. Accordingly, state courts and legislatures have adopted a variety of procedures to protect their interests, for example, requiring verification of a patient's condition by two independent physicians before a surrogate is permitted to terminate treatment,²⁴ or restricting surrogate authority.²⁵ Some have argued, however, that such additional requirements, rather than protecting the patient's interests, actually restrict the right to refuse treatment for patients lacking decision-making capacity, and thus may be discriminatory.

Both the substituted judgment and best interests standards have been sharply criticized. The former, it is argued, is unworkable because patients' character traits, and even their prior statements about medical treatment, may not be a good guide to the choice they would actually make in their present circumstances. The latter standard is seen by some as dehumanizing, since it often focuses attention very narrowly on patients' medical condition, neglecting other considerations which should be viewed as relevant to the choices being made.

Who Should Decide?

Establishing clear standards to guide treatment decisions for those who cannot choose for themselves still leaves unanswered the question of who is best able to implement those standards. When a decision must be made for a patient who can no longer express a personal preference, the patient's autonomy can still be respected by identifying an appropriate surrogate decision-maker. If, prior to losing decision-making capacity, the patient designated a surrogate, we should respect that choice. In cases where we do

not know who the patient would choose as a surrogate, there may be a statutory mechanism for selecting a surrogate decision-maker. A growing number of states have developed such surrogate consent statutes, which usually establish an order in which different family members and others close to the patient may be authorized to make medical decisions for the patient.²⁶ The category of patients for whom decisions are most difficult are those who lack anyone able to serve as surrogate. States have adopted various mechanisms for designating a surrogate in such cases.²⁷

The ethical basis for statutory procedures to designate a family member or close friend is the promotion of individual autonomy through the identification of a surrogate decision-maker who can closely approximate the choices the patient would have made if not incapacitated. The assumption underlying the appointment of such people as surrogates is that they are likely to have firsthand knowledge of the values and goals of the patient. In many instances such an assumption is quite reasonable, and it has been argued that even where no such consent statutes are on the books, the incapacitated patient's family and close friends should have presumptive authority to make treatment decisions.²⁸ Even if we grant such presumptive authority, however, we must be prepared to make exceptions, since not all families, partners and friends share the kind of close relationships required to adequately represent each other's interests. Moreover, recent empirical studies raise questions about the ability of family members and others to duplicate patients' choices. Further undermining the applicability of some family consent statutes is the growing number of non-traditional families, structured in a variety of ways not envisioned by these statutes. Finally, we must recognize the stresses and strains experienced by family members when these difficult decisions must be faced. We need to understand that in these circumstances family members often need each other's support, and guard against pressuring them to make choices that undermine their sense of familial obligations.²⁹

Institutional ethics committees may also play a role in termination of treatment decisions. Health care providers, as well as patients and their families and friends may look to these committees for assistance in making such decisions. Ethics committees do not make treatment decisions, but they

can be very helpful in ensuring that the full range of issues raised by these decisions is addressed. Some courts have even recognized a limited role for ethics committees in the decision process.³⁰

The Cruzan Decision

In June, 1990, in the widely publicized Cruzan case, the U.S. Supreme Court issued its decision in the first "right to die" case to come before that court.³¹ Nancy Cruzan suffered severe brain injuries in an automobile accident in 1983. A month after the accident, while her prognosis was still uncertain, an artificial feeding tube was inserted. In 1986, after her family realized that Nancy would remain permanently in a vegetative state, they requested that the artificial feeding be discontinued because they believed Nancy would not want to continue living in her condition. The state facility in which Nancy was a patient insisted on a court order, so the case entered the legal system, and in 1988 the trial court authorized the termination of artificial feeding. This ruling was reversed, however, when the case was appealed to the Missouri Supreme Court later in the same year.

By a 5 – 4 vote, the U.S. Supreme Court affirmed the ruling of the Missouri Supreme Court. Although the Supreme Court reaffirmed the right of patients to refuse medical treatment, it held that nothing in the U.S. Constitution forbade Missouri from following its restrictive rule. That is, the state of Missouri could require the continued treatment of a permanently unconscious patient unless there was "clear and convincing" evidence that she had explicitly authorized the termination of treatment prior to losing decision-making capacity. Since evidence of Nancy Cruzan's wishes regarding medical care did not meet this stringent standard of proof, the Court agreed that the state of Missouri's interest in preserving life prevailed.³²

After the Supreme Court ruling, the Cruzans petitioned the trial court in Missouri to rehear the case, producing additional evidence to meet the "clear and convincing" standard. The state of Missouri withdrew from the proceedings, leaving no official opposition to the family's request. At the hearing, new witnesses came forward who testified about discussions they had with Nancy before her accident in which she had stated that she would

not want to be "kept alive by machines" if she were a "vegetable". In addition, Nancy's attending physician testified that he had changed his mind and was now in favor of terminating treatment. Within hours of the trial judge's ruling in the family's favor, the artificial feeding was stopped, and Nancy Cruzan died 12 days later.

Advance Directives

In response to the court's decision in *Cruzan*, Missouri's Senator Danforth sponsored the Patient Self-Determination Act (PSDA), the first federal statute on advance directives, which became effective on December 1, 1991.³³ This law applies to all health care institutions receiving Medicare or Medicaid funds. It requires these institutions to provide each adult patient with written information explaining the patient's rights under state law to accept or refuse medical treatment, the right to formulate advance directives, and the institution's policies regarding the implementation of such rights. The legislature or courts of virtually every state now has officially recognized the use of advanced directives.

Advance directives are documents that allow people to retain some control over health care decisions after they have lost the capacity to participate directly in the decision-making process. Directives can take the form of explicit instructions about treatment (such as living wills), the appointment by the patient of a health care agent with authority to make health care decisions on the patient's behalf (such as health care powers of attorney), or a combination of the two.

Living will or natural death statutes have now been enacted in all but three states.³⁴ Despite this widespread acceptance, there is a great deal of variation in the content of these statutes. For example, some state statutes seem to require that a patient be "terminal" or exclude certain treatments such as tube feeding. These restrictions may be contradicted by other law and challengeable, but they introduce confusion. Indeed, language restricting the applicability of living wills to cases where the patient's condition is "terminal" or death is "imminent" does not accurately reflect the patient's broad legal right to refuse treatment. Some states may not recognize the validity of treatment directives executed in another state. In addition to these problems, some people have

questioned whether living wills containing directives regarding specific treatments can accurately reflect a patient's changing interests or be flexible enough to adapt to changing medical circumstances.³⁵

All 50 states and the District of Columbia have durable power of attorney statutes, and only Alaska has not yet enacted laws explicitly recognizing the use of this instrument for purposes of health care decision-making.³⁶ The appointment of a surrogate or proxy decision-maker, using the mechanism of a durable power of attorney for health care, has been promoted as a more flexible instrument for protecting the autonomy of incapacitated patients.³⁷ The authority of the appointed surrogate usually is not limited to decisions about life-sustaining treatment, but extends to all health care decisions. Moreover, guided by the patient's general preferences and specific directions, a surrogate can make contemporaneous decisions, based on all available information about the patient's prognosis, treatment alternatives, and anticipated outcomes.

In recent years, a great deal of empirical research has been conducted concerning the use and effectiveness of advance directives.³⁸ There is widespread recognition that the use of advance directives can help to foster patient autonomy. However, a minority of Americans have such directives, and there will always be at least some people who lack them. There are also problems of interpretation and reliability which limit the usefulness of such documents. It is clear that written advanced directives should not come to be perceived as the only way to approach treatment decisions for the future. In a study conducted at several tertiary care centers, even carefully planned and executed interventions designed to foster autonomous decision-making through improved patient-physician communication were not effective in changing the treatment received by seriously ill patients.³⁹ Further research will be needed to determine why these interventions failed to bring about the desired changes in the outcomes of care. But it appears that in order to be effective, procedural changes will have to address deeply entrenched structural features of our health care delivery system. An important lesson can nonetheless be learned. Perfunctory fulfillment of explicit requirements set forth in the PSDA or institutional policies should not be accepted as a substitute for engaging patients or their surrogates in meaningful dialogue

about values, goals, and the appropriate means to pursue them.⁴⁰

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- * Note: This overview is no substitute for legal advice in individual cases.
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 - 23 In practice, the "best interests" of a patient are assumed to coincide with what most "reasonable persons" would choose in the same circumstances.
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 - 25 *In re Westchester county Medical Center (O'Connor)*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988).
 - 26 More than two-thirds of the states and the District of Columbia have enacted such statutes. There is much variation in the statutes, however, and in some states the authority of surrogates is quite restricted. For an overview, see American Bar Association, Commission on Legal Problems of the Elderly, *Surrogate Decision-Making in Health Care* (June 1993).
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- 32 The Cruzan decision applies only to Missouri. Other states can adopt or reject a clear and convincing evidentiary standard for termination of treatment decisions.
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UNFOLDING ISSUES FOR TERMINATION OF TREATMENT FOR ADULTS

Should health care professionals be required to provide treatment which they believe is medically futile when the treatment is requested by patients or their surrogates?

Should actions resulting in a patient's death be permitted that go beyond the withholding or withdrawing of treatment? That is, should active euthanasia – direct actions to end a patient's life – be permitted?

What should be the legal penalties, if any, for "mercy killings?"

Should health care professionals participate in active euthanasia?

Should active euthanasia, if allowed, be restricted to competent patients?

Should physician-assisted suicide be allowed?

What should be the role of institutional ethics committees in termination of treatment decisions?

How can the interests of patients who lack decisional capacity and also lack someone who can act as surrogate best be protected?

145B.01 Citation.

This chapter may be cited as the "Minnesota living will act."

145B.02 Definitions.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 2. Living will. "Living will" means a writing made according to section 145B.03.

Subd. 3. Health care. "Health care" means care, treatment, services, or procedures to maintain, diagnose, or treat an individual's physical condition when the individual is in a terminal condition.

Subd. 4. Health care decision. "Health care decision" means a decision to begin, continue, increase, limit, discontinue, or not begin any health care.

Subd. 5. Health care facility. "Health care facility" means a hospital or other entity licensed under sections 144.50 to 144.58; a nursing home licensed to serve adults under section 144A.02; or a home care provider licensed under sections 144A.43 to 144A.49.

Subd. 6. Health care provider. "Health care provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care directly or through an arrangement with other health care providers.

Subd. 7. HMO. "HMO" means an organization licensed under sections 62D.01 to 62D.30.

Subd. 8. Terminal condition. "Terminal condition" means an incurable or irreversible condition for which the administration of medical treatment will serve only to prolong the dying process.

145B.03 Living will.

Subdivision 1. Scope. A competent adult may make a living will of preferences or instructions regarding health care.

These preferences or instructions may include, but are not limited to, consent to or refusal of any health care, treatment, service, procedure, or placement. A living will may include preferences or instructions regarding health care, the designation of a proxy to make health care decisions on behalf of the declarant, or both.

Subd. 2. Requirements for executing a living will. (a) A living will is effective only if it is signed by the declarant and two witnesses or a notary public.

(b) A living will must state:

(1) the declarant's preferences regarding whether the declarant wishes to receive or not receive artificial administration of nutrition and hydration; or

(2) that the declarant wishes the proxy, if any, to make decisions regarding the administering of artificially administered nutrition and hydration for the declarant if the declarant is unable to make health care decisions and the living will becomes operative. If the living will does not state the declarant's preferences regarding artificial administration of nutrition and hydration, the living will shall be enforceable as to all other preferences or instructions regarding health care, and a decision to administer, withhold, or withdraw nutrition and hydration artificially shall be made pursuant to section 145B.13. However, the mere existence of a living will or appointment of a proxy does not, by itself, create a presumption that the declarant wanted the withholding or withdrawing of artificially administered nutrition or hydration.

(c) The living will may be communicated to and then transcribed by one of the witnesses. If the declarant is physically unable to sign the document, one of the witnesses shall sign the document at the declarant's direction.

(d) Neither of the witnesses can be someone who is entitled to any part of the estate of the declarant under a will then existing or by operation of law. Neither of the witnesses

nor the notary may be named as a proxy in the living will. Each witness shall substantially make the following declaration on the document:

"I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will."

Subd. 3. Guardian or conservator. Except as otherwise provided in the living will, designation of a proxy is considered a nomination of a guardian or conservator of the person for purposes of section 525.544.

145B.04 Suggested form.

A living will executed after August 1, 1989, under this chapter must be substantially in the form in this section. Forms printed for public distribution must be substantially in the form in this section.

"Health Care Living Will

Notice:

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

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy, that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the living will at any time by notifying your health care providers.

(d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE:

I,, born on (birthdate), being an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my health care. I understand that my health care providers are legally bound to act consistently with my wishes, within the limits of reasonable medical practice and other applicable law. I also understand that I have the right to make medical and health care decisions for myself as long as I am able to do so and to revoke this living will at any time.

(1) The following are my feelings and wishes regarding my health care (you may state the circumstances under which this living will applies):

.....
.....
.....
.....
.....
.....
.....

(2) I particularly want to have all appropriate health care that will help in the following ways (you may give instructions for care you do want):

.....
.....
.....
.....
.....
.....

(3) I particularly do not want the following (you may list specific treatment you do not want in certain circumstances):

.....
.....
.....

(4) I particularly want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do want if you have a terminal condition):

.....
.....
.....
.....
.....
.....

(5) I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition):

.....
.....
.....
.....
.....
.....

(6) I recognize that if I reject artificially administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially administered sustenance should I have a terminal condition (you may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition):

.....
.....
.....
.....
.....
.....

(7) Thoughts I feel are relevant to my instructions. (You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care.)

.....
.....
.....
.....
.....
.....

(8) Proxy Designation. (If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.)

If I become unable to communicate my instructions, I designate the following person(s) to act on my behalf consistently with my instructions, if any, as stated in this document. Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian or conservator of the person is to be appointed for me, I nominate my proxy named in this document to act as guardian or conservator of my person.

Name:

Address:

Phone Number:

Relationship: (If any)

If the person I have named above refuses or is unable or unavailable to act on my behalf, or if I revoke that person's authority to act as my proxy, I authorize the following person to do so:

Name:

Address:

Phone Number:

Relationship: (If any)

I understand that I have the right to revoke the appointment of the persons named above to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

(9) Organ Donation After Death. (If you wish, you may indicate whether you want to be an organ donor upon your death.) Initial the statement which expresses your wish:

..... In the event of my death, I would like to donate my organs. I understand that to become an organ donor, I must be declared brain dead. My organ function may be maintained artificially on a breathing machine, (i.e., artificial ventilation), so that my organs can be removed.

Limitations or special wishes: (If any)

.....
.....
.....

I understand that, upon my death, my next of kin may be asked permission for donation. Therefore, it is in my best interests to inform my next of kin about my decision ahead of time and ask them to honor my request.

I (have) (have not) agreed in another document or on another form to donate some or all of my organs when I die.

..... I do not wish to become an organ donor upon my death.

DATE:

SIGNED:

STATE OF

COUNTY OF

Subscribed, sworn to, and acknowledged before me by on this day of, 19...

.....
NOTARY PUBLIC

OR

(Sign and date here in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a will or by operation of law, and neither of whom is your proxy.)

I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will, and to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a will or by operation of law.

Witness Address

.....
Witness Address

.....
Reminder: Keep the signed original with your personal papers.

Give signed copies to your doctors, family, and proxy."

145B.05 When operative.

A living will becomes operative when it is delivered to the declarant's physician or other health care provider. The physician or provider must comply with it to the fullest extent possible, consistent with reasonable medical practice and other applicable law, or comply with the notice and transfer provisions of sections 145B.06 and 145B.07. The physician or health care provider shall continue to obtain the declarant's informed consent to all health care decisions if the declarant is capable of informed consent.

145B.06 Compliance with living will.

Subdivision 1. By health care provider. (a) A physician or other health care provider shall make the living will a part of the declarant's medical record. If the physician or other health care provider is unwilling at any time to comply with the living will, the physician or health care provider must promptly notify the declarant and document the notification in the declarant's medical record. After notification, if a competent declarant fails to transfer to a different physician or provider, the physician or provider has no duty to transfer the patient.

(b) If a physician or other health care provider receives a living will from a competent declarant and does not advise the declarant of unwillingness to comply, and if the declarant then becomes incompetent or otherwise unable to seek transfer to a different physician or provider, the physician or other health care provider who is unwilling to comply with the living will shall promptly take all reasonable steps to transfer care of the declarant to a physician or other health care provider who is willing to comply with the living will.

Subd. 2. By proxy. A proxy designated to make health care decisions and who agrees to serve as proxy may make health care decisions on behalf of a declarant to the same

extent that the declarant could make the decision, subject to limitations or conditions stated in the living will. In exercising this authority, the proxy shall act consistently with any desires the declarant expresses in the living will or otherwise makes known to the proxy. If the declarant's desires are unknown, the proxy shall act in the best interests of the declarant.

145B.07 Transfer of care.

If a living will is delivered to a physician or other health care provider who transfers care of patients to other health care providers, or if a living will is delivered to a health care provider, including a health care facility or HMO that delivers patient care through an arrangement with individual providers, the physician or other health care provider receiving a living will shall make reasonable efforts:

(1) to ensure that an agreement with the patient to comply with the living will will be honored by others who provide health care to that patient; or

(2) to identify and deliver the living will to the individual providers and facilitate the declarant's discussion with those individuals whose agreement to comply with the living will is required.

145B.08 Access to medical information by proxy.

Unless a living will under this chapter provides otherwise, a proxy has the same rights as the declarant to receive information regarding proposed health care, to receive and review medical records, and to consent to the disclosure of medical records for purposes related to the declarant's health care or insurance.

145B.09 Revocation.

Subdivision 1. General. A living will under this chapter may be revoked in whole or in part at any time and in any manner by the declarant, without regard to the declarant's physical or mental condition. A revocation is effective when the declarant communicates it to the attending physician or other health care provider. The attending physician or other health care provider shall note the revocation as part of the declarant's medical record.

Subd. 2. Effect of marriage dissolution or annulment on designation of proxy. Unless a living will under this chapter expressly provides otherwise, if after executing a living will the declarant's marriage is dissolved or annulled, the dissolution or annulment revokes any designation of the former spouse as a proxy to make health care decisions for the declarant.

145B.105 Penalties.

Subdivision 1. Gross misdemeanor offenses. Whoever commits any of the following acts is guilty of a gross misdemeanor:

(1) willfully conceals, cancels, defaces, or obliterates a living will of a declarant without the consent of the declarant;

(2) willfully conceals or withholds personal knowledge of a revocation of a living will;

(3) falsifies or forges a living will or a revocation of a living will;

(4) coerces or fraudulently induces another to execute a living will; or

(5) requires or prohibits the execution of a living will as a condition for being insured for or receiving all or some health care services.

Subd. 2. Felony offenses. Whoever commits an act prohibited under subdivision 1 is guilty of a felony if the act results in bodily harm to the declarant or to the person who would have been a declarant but for the unlawful act.

145B.11 Effect on insurance.

The making or effectuation of a living will under this chapter does not affect the sale, procurement, issuance, or validity of a policy of life insurance or annuity, nor does it

affect, impair, or modify the terms of an existing policy of life insurance or annuity or the liability of the party issuing the policy or annuity contract.

145B.12 What if there is no living will or proxy?

Subdivision 1. No presumption created. If an individual has not executed or has revoked a living will under this chapter, a presumption is not created with respect to:

- (1) the individual's intentions concerning the provision of health care; or
- (2) the appropriate health care to be provided.

Subd. 2. Nutrition or hydration. Nothing in this chapter shall be construed to authorize or justify the withholding or withdrawal of artificially administered nutrition or hydration from any person who has not issued a living will or designated a proxy under this chapter.

145B.13 Reasonable medical practice required.

In reliance on a patient's living will, a decision to administer, withhold, or withdraw medical treatment after the patient has been diagnosed by the attending physician to be in a terminal condition must always be based on reasonable medical practice, including:

- (1) continuation of appropriate care to maintain the patient's comfort, hygiene, and human dignity and to alleviate pain;
- (2) oral administration of food or water to a patient who accepts it, except for clearly documented medical reasons; and
- (3) in the case of a living will of a patient that the attending physician knows is pregnant, the living will must not be given effect as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

145B.14 Certain practices not condoned.

Nothing in this chapter may be construed to condone, authorize, or approve mercy killing, euthanasia, suicide, or assisted suicide.

145B.15 Recognition of previously executed living will.

A living will that substantially complies with section 145B.03, but is made before August 1, 1989, is an effective living will under this chapter.

145B.16 Recognition of document executed in another state.

A living will executed in another state is effective if it substantially complies with this chapter.

145B.17 Existing rights.

Nothing in this chapter impairs or supersedes the existing rights of any patient or any other legal right or legal responsibility a person may have to begin, continue, withhold, or withdraw health care. Nothing in this chapter prohibits lawful treatment by spiritual means through prayer in lieu of medical or surgical treatment when treatment by spiritual means has been authorized by the declarant.

145C.01 Definitions.

Subdivision 1. Applicability. The definitions in this section apply to this chapter.

Subd. 2. Agent. "Agent" means an individual age 18 or older who is designated by a principal in a durable power of attorney for health care to make health care decisions on behalf of a principal and has consented to act in that capacity. An agent may also be referred to as "attorney in fact."

Subd. 3. Durable power of attorney for health care. "Durable power of attorney for health care" means an instrument authorizing an agent to make health care decisions for the principal if the principal is unable, in the judgment of the attending physician, to make or communicate health care decisions.

Subd. 4. Health care. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat a person's physical or mental condition. "Health care" includes the provision of nutrition or hydration parenterally or through intubation. "Health care" does not include intrusive mental health treatment as defined in section 253B.03, subdivision 6b, unless the durable power of attorney for health care specifically applies to decisions relating to intrusive mental health treatment.

Subd. 5. Health care decision. "Health care decision" means the consent, refusal of consent, or withdrawal of consent to health care.

Subd. 6. Health care provider. "Health care provider" means a person, health care facility, organization, or corporation licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care directly or through an arrangement with other health care providers, including health maintenance organizations licensed under chapter 62D.

Subd. 7. Health care facility. "Health care facility" means a hospital or other entity licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under section 144A.02, or a home care provider licensed under sections 144A.43 to 144A.49.

Subd. 8. Principal. "Principal" means an individual age 18 or older who has executed a durable power of attorney for health care.

145C.02 Durable power of attorney for health care.

A durable power of attorney for health care under this chapter authorizes the agent to make health care decisions for the principal when the principal is unable, in the judgment of the principal's attending physician, to make or communicate health care decisions. The durable power of attorney for health care must substantially comply with the requirements of this chapter. An instrument executed prior to August 1, 1993, purporting to create a durable power of attorney for health care is valid if the document specifically authorizes the agent to make health care decisions and is executed in compliance with section 145C.03.

145C.03 Requirements.

Subdivision 1. Execution. A durable power of attorney for health care must be signed by the principal or in the principal's name by some other individual acting in the principal's presence and by the principal's direction. A durable power of attorney for health care must contain the date of its execution and must be witnessed or acknowledged by one of the following methods:

(1) signed by at least two individuals age 18 or older each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgment of the signature; or

(2) acknowledged by the principal before a notary public who is not the agent.

Subd. 2. Individuals ineligible to act as agent. The following individuals are not eligible to act as the agent in a durable power of attorney for health care, unless the individual designated is related to the principal by blood, marriage, registered domestic partnership, or adoption:

(1) a health care provider attending the principal; or

(2) an employee of a health care provider attending the principal.

Subd. 3. Individuals ineligible to act as witnesses. The agent designated in the durable power of attorney for health care may not act as a witness for the execution of the durable power of attorney for health care.

At least one witness to the execution of the durable power of attorney for health care must not be a health care provider providing direct care to the principal or an employee of a health care provider providing direct care to the principal on the date of execution.

145C.04 Executed in another state.

A durable power of attorney for health care or similar document executed in another state or jurisdiction in compliance with the law of that state or jurisdiction is valid and enforceable in this state, to the extent the document is consistent with the laws of this state.

145C.05 Suggested form.

Subdivision 1. Content. A durable power of attorney for health care executed pursuant to this chapter may, but need not, be in the following form:

"I appoint as my agent (my attorney in fact) to make any health care decision for me when, in the judgment of my attending physician, I am unable to make or communicate the decision myself and my agent consents to make or communicate the decision on my behalf.

My agent has the power to make any health care decision for me. This power includes the power to give consent, to refuse consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition, including giving me food or water by artificial means. My agent has the power, where consistent with the laws of this state, to make a health care decision to withhold or stop health care necessary to keep me alive. It is my intention that my agent or any alternative agent has a personal obligation to me to make health care decisions for me consistent with my expressed wishes. I understand, however, that my agent or any alternative agent has no legal duty to act.

My agent and any alternative agents have consented to act as my agent. My agent and any alternative agents have been notified that they will be nominated as a guardian or conservator for me.

My agent must act consistently with my desires as stated in this document or as otherwise made known by me to my agent.

My agent has the same right as I would have to receive, review, and obtain copies of my medical records and to consent to disclosure of those records."

Subd. 2. Additional provisions. The durable power of attorney for health care may include additional provisions consistent with this chapter, including:

- (1) the designation of one or more alternative agents to act if the named agent is unable, unavailable, or unwilling to serve;
- (2) specific instructions to the agent or any alternative agents;
- (3) limitations, if any, on the right of the agent or any alternative agents to receive, review, obtain copies of, and consent to the disclosure of the principal's medical records;
- (4) limitations, if any, on the nomination of the agent as guardian or conservator for purposes of section 525.544; and
- (5) a document of gift for the purpose of making an anatomical gift, as set forth in sections 525.921 to 525.9224, or an amendment to, revocation of, or refusal to make an anatomical gift.

145C.06 When effective.

(a) Except as provided in paragraph (b), a durable power of attorney for health care is effective for a health care decision when:

- (1) it has been executed in accordance with section 145C.03; and
- (2) the principal is unable, in the determination of the attending physician of the principal, to make or communicate that health care decision and the agent consents to make or communicate the decision.

(b) If the principal states in the durable power of attorney that the principal does not have an attending physician because the principal in good faith generally selects and depends upon spiritual means or prayer for the treatment or care of disease or remedial care, the principal may designate an individual in the durable power of attorney for health care who may certify in a writing acknowledged before a notary public that the principal is unable to make or communicate a health care decision. The requirements of section 145C.03, subdivisions 2 and 3, relating to the eligibility of a health care provider attending the principal or the provider's employee to act as an agent or witness apply to an individual designated under this paragraph.

145C.07 Authority and duties of agent.

Subdivision 1. Authority. The agent has authority to make any particular health care decision only if the principal is unable, in the determination of the attending physician, to make or communicate that health care decision. The agent does not have authority to consent to a voluntary commitment under chapter 253B. The physician or health care provider shall continue to obtain the principal's informed consent to all health care decisions for which the principal is capable of informed consent.

Subd. 2. Agent as guardian. Except as otherwise provided in the durable power of attorney for health care, appointment of the agent in a durable power of attorney for health care is considered a nomination of a guardian or conservator of the person for purposes of section 525.544.

Subd. 3. Duties. In exercising the authority under the durable power of attorney for health care, the agent has a duty to act in accordance with the desires of the principal as expressed in the durable power of attorney for health care, as expressed in a living will under chapter 145B or in a declaration regarding intrusive mental health treatment under section 253B.03, subdivision 6d, or as otherwise made known by the principal to the agent at any time. If the principal's desires are not known or cannot be determined from information known to the agent, the agent has a duty to act in the best interests of the principal taking into account the principal's overall medical condition and prognosis. An agent or any alternative agent has a personal obligation to the principal to make health care decisions authorized by the durable power of attorney for health care but this obligation does not constitute a legal duty to act.

Subd. 4. Inconsistencies among documents. In the event of inconsistency between the designation of a proxy under chapter 145B or section 253B.03, subdivision 6d, or of an agent under this chapter, the most recent designation takes precedence. In the event of other inconsistencies among documents executed under this chapter, under chapter 145B, or under section 253B.03, subdivision 6d, or 525.544, the provisions of the most recently executed document take precedence only to the extent of the inconsistency.

145C.08 Authority to review medical records.

An agent acting pursuant to a durable power of attorney for health care has the same right as the principal to receive, review, and obtain copies of medical records of the principal, and to consent to the disclosure of medical records of the principal, unless the durable power of attorney for health care expressly provides otherwise.

145C.09 Revocation of durable power of attorney.

Subdivision 1. Revocation. The principal may revoke a durable power of attorney for health care at any time by doing any of the following:

(1) canceling, defacing, obliterating, burning, tearing, or otherwise destroying the durable power of attorney for health care instrument or directing another in the presence of the principal to destroy the durable power of attorney for health care instrument;

(2) executing a statement, in writing and dated, expressing the principal's intent to revoke the durable power of attorney for health care;

(3) verbally expressing the principal's intent to revoke the durable power of attorney for health care in the presence of two witnesses who do not have to be present at the same time; or

(4) executing a subsequent durable power of attorney for health care instrument, to the extent the subsequent instrument is inconsistent with any prior instrument.

Subd. 2. Effect of dissolution or annulment of marriage or termination of domestic partnership on appointment of agent. Unless the durable power of attorney for health care expressly provides otherwise, the appointment by the principal of the principal's spouse or domestic partner as agent under a durable power of attorney for health care is revoked by the commencement of proceedings for dissolution, annulment, or termination of the

principal's marriage or commencement of proceedings for termination of the principal's registered domestic partnership.

145C.10 Presumptions.

The principal is presumed to have capacity to appoint an agent to make health care decisions and to revoke a durable power of attorney for health care. A health care provider or agent may presume that a durable power of attorney for health care is valid absent actual knowledge to the contrary.

It is presumed that an agent, and a health care provider acting pursuant to the direction of an agent, are acting in good faith and in the best interests of the principal, absent clear and convincing evidence to the contrary.

This chapter does not create a presumption concerning the intention of an individual who has not executed a durable power of attorney for health care and does not impair or supersede any right or responsibility of an individual to consent, refuse to consent, or withdraw consent to health care on behalf of another in the absence of a durable power of attorney for health care.

For purposes of this chapter, acting in good faith means acting consistently with the desires of the principal as expressed in the durable power of attorney for health care, as expressed in a living will under chapter 145B or in a declaration regarding intrusive mental health treatment under section 253B.03, subdivision 6d, or otherwise made known by the principal to the agent. If the principal's desires are not known or cannot be determined from information known to the agent, acting in good faith means acting in the best interests of the principal, taking into account the principal's overall medical condition and prognosis.

145C.11 Immunities.

Subdivision 1. Agent. An agent is not subject to criminal prosecution or civil liability for any health care decision made in good faith pursuant to a durable power of attorney for health care, unless the agent has actual knowledge of the revocation of the durable power of attorney for health care.

Subd. 2. Health care provider. (a) A health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider relies on a health care decision made by the agent and the following requirements are satisfied:

(1) the health care provider believes in good faith that the decision was made by an agent authorized to make the decision and has no actual knowledge that the durable power of attorney for health care has been revoked; and

(2) the health care provider believes in good faith that the decision is consistent with the desires of the principal as expressed in the durable power of attorney for health care or otherwise made known by the principal to the agent.

(b) A health care provider who administers health care necessary to keep the principal alive, despite a health care decision of the agent to withhold or withdraw that treatment, is not subject to criminal prosecution, civil liability, or professional disciplinary action if that health care provider promptly took all reasonable steps to transfer care of the principal to another health care provider willing to comply with the decision of the agent.

145C.12 Prohibited practices.

Subdivision 1. Health care provider. A health care provider, health care service plan, insurer, self-insured employee welfare benefit plan, or nonprofit hospital plan may not condition admission to a facility, or the providing of treatment or insurance, on the requirement that an individual execute a durable power of attorney for health care.

Subd. 2. Insurance. A policy of life insurance is not legally impaired or invalidated in any manner by the withholding or withdrawing of health care pursuant to the direction of an agent appointed pursuant to this chapter.

145C.13 Penalties.

Subdivision 1. Gross misdemeanor offenses. Whoever commits any of the following acts is guilty of a gross misdemeanor:

(1) willfully conceals, cancels, defaces, or obliterates a durable power of attorney for health care of a principal without the consent of the principal;

(2) willfully conceals or withholds personal knowledge of a revocation of a durable power of attorney for health care;

(3) falsifies or forges a durable power of attorney for health care or a revocation of the instrument;

(4) coerces or fraudulently induces another to execute a durable power of attorney for health care; or

(5) requires or prohibits the execution of a durable power of attorney for health care as a condition for being insured for or receiving all or some health care services.

Subd. 2. Felony offenses. Whoever commits an act prohibited under subdivision 1 is guilty of a felony if the act results in bodily harm to the principal or to the person who would have been a principal but for the unlawful act.

145C.14 Certain practices not condoned.

Nothing in this chapter may be construed to condone, authorize, or approve mercy killing or euthanasia.

145C.15 Duties of health care providers to provide life-sustaining health care.

(a) If a proxy acting under chapter 145B or an agent acting under this chapter directs the provision of health care, nutrition, or hydration that, in reasonable medical judgment, has a significant possibility of sustaining the life of the principal or declarant, a health care provider shall take all reasonable steps to ensure the provision of the directed health care, nutrition, or hydration if the provider has the legal and actual capability of providing the health care either itself or by transferring the principal or declarant to a health care provider who has that capability. Any transfer of a principal or declarant under this paragraph must be done promptly and, if necessary to preserve the life of the principal or declarant, by emergency means. This paragraph does not apply if a living will under chapter 145B or a durable power of attorney for health care indicates an intention to the contrary.

(b) A health care provider who is unwilling to provide directed health care under paragraph (a) that the provider has the legal and actual capability of providing may transfer the principal or declarant to another health care provider willing to provide the directed health care but the provider shall take all reasonable steps to ensure provision of the directed health care until the principal or declarant is transferred.

(c) Nothing in this section alters any legal obligation or lack of legal obligation of a health care provider to provide health care to a principal or declarant who refuses, has refused, or is unable to pay for the health care.

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