

Establishing an advance directive

An advance directive is a written statement of your wishes for health care should you not be able to make your own care decisions (for example, if you are in a coma). It lets you decide the medical treatments you want and authorizes someone you know and trust to make decisions for you when you cannot do so.

We've provided a Durable Power of Attorney for Health Care form with this attachment. This form is intended for use in Michigan only; other states have different requirements for advance directives. Some organizations, such as the Michigan State Medical Society, also provide advance directive forms. You may use any form or document as long as it meets the requirements of Michigan law. You do not need an attorney for this procedure to take effect.

It is against the law for health care providers or insurers to require you to complete an advance directive as a condition of coverage or treatment. Federal law requires your primary care physician to ask if you have an advance directive and to write your answer in your medical record.

Before completing the forms, be sure to speak with your physician about your health and potential future health needs. You will also want to discuss your wishes with family and friends.

We're providing this information to help our patients become informed health care consumers who make their wishes known. Whether you fill out the form is strictly your choice.

Guidelines for an advance directive

1. Talk with your doctor about the kinds of treatment decisions you might need to make in the future.
2. Complete the Patient's Advance Directive, checking the treatments you want and those you don't. You can also write additional instructions on a separate sheet of paper and attach it to the form.
3. Identify a person you trust to speak on your behalf if you become unable to express your decisions about health care. This person – your patient advocate – will work with your doctors to make the decisions you would make for yourself if you could. The person you appoint as your advocate must acknowledge his or her rights and responsibilities by signing the Acceptance by Patient Advocate form.
4. Fill out and sign the Durable Power of Attorney for Health Care form in the presence of two witnesses. You don't need an attorney. However, you may want to consult your personal attorney or an attorney experienced in probate law or elder law, especially if you do not use a preprinted form.
5. Sign the form, and ask the witnesses to sign it.
6. Give a copy of the form to your primary care physician, your patient advocate, your personal attorney and anyone else who might be affected by your decision to have an advance directive. If you enter a nursing home or hospital, make sure that the facility has a copy too. Keep your copy of your advance directive in a safe place where it can easily be found.

We encourage you to discuss your treatment choices with your primary care physician, your designated patient advocate and members of your family.

Questions and answers about advance directives

Q. What is an advance directive?

An advance directive is a document that states how you want medical decisions made if you lose the ability to make them for yourself. There are two types of advance directives: Durable Power of Attorney for Health Care and living wills.

Q. What is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a legally binding document in which you appoint an advocate to make medical decisions for you if you become unable to make them for yourself.

Q. What is a living will?

A living will is a document that is authorized in some states although not in Michigan. It identifies which medical treatments you would want – and which you would refuse – if you became terminally ill. For example, you could authorize blood transfusions and IV therapy, but refuse ventilator care or artificial nutrition. Living wills are not authorized by Michigan law.

Q. Must I have an advance directive?

No. Advance directives are strictly voluntary. It's against the law for health care providers or insurance companies to require them as a condition of treatment or coverage.

Q. Who can establish a Durable Power of Attorney for Health Care?

Anyone at least 18 years old and legally competent can establish a Durable Power of Attorney for Health Care.

Q. How does it work?

You select someone you trust, who is at least 18 years old, to be your patient advocate. Then you fill out the form in the presence of two witnesses, and you and the witnesses sign it. (Under Michigan law, a doctor does not have to honor your Durable Power of Attorney for Health Care form unless two witnesses sign it.)

Your advocate starts to make decisions on your behalf only when your attending doctor and another doctor or a licensed psychologist determine you are no longer able to make decisions for yourself. Your advocate has the authority to work with your doctors to make the same decisions you would make if you could, as documented in your Durable Power of Attorney for Health Care form.

Q. Who can witness my Durable Power of Attorney for Health Care form?

Your witnesses must be at least 18 years old. Under Michigan law, witnesses cannot be: your spouse, parent, child, grandchild, brother or sister, someone who benefits under your will, your patient advocate, your doctor, someone employed by your life or health insurance company, someone employed at a health care facility where you receive treatment, or someone employed by the home for the aged where you live.

Q. What is the Acceptance by Patient Advocate form?

The person you appoint as your advocate must acknowledge his or her rights and responsibilities by signing the Acceptance by Patient Advocate form. If your advocate does not sign the form, your Durable Power of Attorney for Health Care may not be honored. It's a good idea to make this form and the Durable Power of Attorney for Health Care form part of your medical record at the same time.

Q. Do I need an attorney to establish a Durable Power of Attorney for Health Care?

No, you only need to fill out the form, sign it and have two witnesses sign it. If you have questions, you may want to consult your family attorney or an attorney who specializes in probate law or elder law.

Q. Should I use the forms provided?

If you wish. Other versions of the form are available through hospital and attorneys. The forms provided are intended for use in Michigan only; other states have different advance directives.

Q. I know my advocate can ensure that I receive every available treatment or end life-sustaining medical treatments if I give him or her written permission. What other kinds of decisions can my advocate make?

With your written permission, your advocate can make decisions about routine care like eating and taking medications. Your advocate can also decide whether you receive care in a nursing home, an assisted living apartment or from home health aides in your own home.

Q. Can I authorize my advocate to withhold or end artificial nutrition and hydration?

Yes, because they are considered life-sustaining treatments. If you want your advocate to withhold these treatments, you must document your wishes and acknowledge that you understand withholding these treatments could allow you to die.

Q. Can I authorize my advocate to make sure I receive all available treatments?

Yes. The Patient's Advance Directive includes a checklist where you can indicate which treatments you want and which you refuse. You can also document additional instructions on a separate sheet of paper and attach it to the form.

Q. Can I designate someone to manage my financial affairs in a Durable Power of Attorney for Health Care?

No. The person you designate in a Durable Power of Attorney for Health Care can only make health care decisions. If you want to appoint someone to handle your financial or legal affairs, you should consult an attorney.

Q. Can I change my Durable Power of Attorney for Health Care?

Yes. You can revoke it any time and in any way you are able to communicate your wishes. You can also appoint a different patient advocate or change your wishes regarding medical care by signing a new Durable Power of Attorney for Health Care form.

Q. Is there a procedure to make sure my advocate is acting according to my wishes?

If you believe your advocate is not acting according to your wishes, you can file a petition with the probate court in the county where you live.

Q. How can I get more information about advance directives?

You can discuss your advance directive and your wishes with your primary care physician.

Durable Power of Attorney for Health Care

I, _____ of _____ Michigan,
(Name)

hereby appoint _____
(Patient Advocate)

residing at _____,
(Patient Advocate Address)

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 treatment decisions.

If the first individual is unable, unwilling or unavailable to serve as my patient advocate,

then I designate _____
(Successor Patient Advocate)

residing at _____
(Successor Patient 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 item)

- A. To have access to and control over my medical and other person information.
- B. To employ and discharge physicians, nurses, therapists and any 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 that I may need or to discontinue care that I am receiving.
- E. To make 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 any 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 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.

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

(Signature)

(Date)

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 undue influence.)

Name and Addresses of Witnesses:

(Witness 1 Name)

(Witness 1 Address)

(Witness 1 Signature)

(Witness 2 Name)

(Witness 2 Address)

(Witness 2 Signature)

(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, an 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.)

Patient's Advance Directive

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 the 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 an 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 that 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 regards to the following forms of treatment:

(Please check your choices)

- | | | | | |
|-------------------------------|--------------------------|-----------|--------------------------|---------------|
| Cardiac resuscitation | <input type="checkbox"/> | I do want | <input type="checkbox"/> | I do not want |
| Mechanical respiration | <input type="checkbox"/> | I do want | <input type="checkbox"/> | I do not want |
| Feeding tubes | <input type="checkbox"/> | I do want | <input type="checkbox"/> | I do not want |
| Kidney dialysis | <input type="checkbox"/> | I do want | <input type="checkbox"/> | I do not want |
| Chemotherapy | <input type="checkbox"/> | I do want | <input type="checkbox"/> | I do not want |
| Antibiotics | <input type="checkbox"/> | I do want | <input type="checkbox"/> | I do not want |
| Intravenous fluids | <input type="checkbox"/> | I do want | <input type="checkbox"/> | I do not want |

(For additional instructions add pages as necessary.)

These directives express my right to refuse treatment and they are 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 or by a clear oral expression that I have changed my mind.

(Signature)

(Date)

(Witness)

Witness

My designated decision maker is _____

Whose address and current phone is _____

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

Acceptance by Patient Advocate

- A. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.
- B. A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment That the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.
- C. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant person's death.
- D. A patient advocate may make a decision to withhold or withdraw treatment that would allow a patient to die only if the patient expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
- E. A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.
- F. A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.
- G. A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
- H. A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
- I. A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

I understand the above conditions and I accept the designation as patient advocate for

Dated: _____ Signed _____
(Patient Advocate)

Dated: _____ Signed _____
(Successor Patient Advocate)