

# ADVANCE DIRECTIVES FOR HEALTH CARE:

## MICHIGAN'S PATIENT ADVOCATE LAW

### QUESTIONS AND ANSWERS

#### Advance Directive for Health Care

1. What is an "advance directive"?

An advance directive is a written document in which a competent individual gives instructions about his/her health care, that will be implemented at some future time should that person lack the ability to make decisions for him or herself.

2. Must I have an advance directive?

No. The decision to have an advance directive is purely voluntary. No family member, hospital, or insurance company can force you to have one or dictate what the document should say if you decide to write one.

3. Are there different types of advance directives?

Yes. There are two types, a durable power of attorney for health care and a living will. Living wills are not recognized in Michigan law. However, in case of a dispute as to your health care desires, your written or oral statements regarding your wishes pertaining to health care or the withdrawal or refusal of treatment, may be used as evidence in court, if you are unable to participate in health care decisions. You may wish to consult an attorney for further information regarding durable powers of attorney or living wills.

4. What is a "durable power of attorney for health care"?

A durable power of attorney for health care, also known as a health care proxy, is a document in which you give another person the power to make medical treatment and related personal care and custody decisions for you.

5. Is a durable power attorney for health care legally binding in Michigan?

Yes, based on a state law passed in 1990.

6. Who is eligible to create a durable power of attorney for health care?

Anyone who is 18 years of age or older and of sound and mind is eligible.

7. What is the title of the person to whom I give decision-making power?

That person is known as a "patient advocate."

8. Who may I appoint as a patient advocate?

Anyone who is 18 years of age or older may be appointed. You should choose someone you trust, who can handle the responsibility, and who is willing to serve.

9. Does a patient advocate need to accept the responsibility before acting?

Yes, he or she must sign an acceptance. This does not have to be done at the time you sign the document. Nevertheless, you should speak to the person your propose to name as patient advocate to make sure he or she is willing to serve.

10. When can the patient advocate act in my behalf?

The patient advocate can make decisions for you only when you are unable to participate in medical treatment decisions.

11. Why might I be unable to participate in medical treatment decisions?

You may become temporarily or permanently unconscious from disease, accident or surgery. You may be awake but mentally unable to make decisions about your care due to disease or injury.

12. Who determines that I am no longer able to participate in these decisions?

Your attending physician and one other physician or licensed psychologist will make that determination. If your religious beliefs prohibit an examination to make this determination, and this is stated in the designation document, you would indicate in the document how it would be determined when the patient advocate can act.

13. What powers can I give a patient advocate?

You can give a patient advocate the power to make those personal care decisions you normally make for yourself. For example, you can give your patient advocate power to consent to or refuse medical treatment for you, to contract for home health care or adult day care, arrange care in a nursing home, or move you to a home for the aged. Note that according to state law, of you were to become incompetent while pregnant, you patient advocate could not authorize a medical treatment decision that would result in your death while pregnant.

14. Can I give my patient advocate the authority to make decisions to withhold or withdraw life-sustaining treatment, including food and water administered through tubes?

Yes, but you must express in a clear and convincing manner that the patient advocate is authorized to make such decisions, and you must acknowledge that these decisions could or would allow your death. If you have specific desires as to when you want to forego life-sustaining treatment, you should make them clear to your advocate. You may also include them as written instructions in your durable power document.

15. Do I have the right to express in the document my wishes concerning medical treatment and personal care?

Yes. You might, for example, express your wishes concerning the type of care you want during terminal illness. You might also express a desire not to be placed in a nursing home and a desire to die at home. Your patient advocate has a duty to try to follow your wishes.

16. Is it important to express my wishes in the durable power of attorney for health care designating document?

Yes. Your wishes might not be followed if others are unaware of them. It can also be a great burden for your patient advocate to make a decision for you without your specific guidance.

17. Can I appoint a second person to serve as patient advocate in case the first-named person is unable to serve?

Yes.

18. Must a durable power of attorney for health care designated document be witnessed?

Yes. Two witnesses must sign. The witnesses must not include your spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, or patient advocate; an employee of your life or health insurance provider; an employee of a health facility that is treating you; or an employee of a home for the aged as defined in section 20106 of the Public Health Code, Act No. 368 of the public Acts of 1978, being Section 333.20106 of the Michigan Compiled Laws, where you reside.

19. In general, what should I do before completing an advance directive?

Take your time. Consider whom you might choose to be your proxy, or to act in your place. Think about your treatment wishes. Discuss the issue with family members and your doctor. Talk with your minister, rabbi, priest, or other spiritual leader if you feel it would be helpful.

20. Are there issues I should give particular attention to?

Yes. Many people have strong feelings about the administration of food and water, either by tube down their throat, a tube placed surgically into their stomach, or intravenously. You may wish to consider and indicate in what circumstances, if any, you wish such procedures withheld or withdrawn. Also, bear in mind that people's opinions regarding their own health care may change over time. Your wishes regarding their own health care may change over time. Your wishes regarding medical treatment when you are relatively young may be quite different from your wishes when you reach advanced age, so you may wish to review your decisions periodically with your patient advocate.

21. Is there a standard form for an advance directive?

Absolutely not. While this pamphlet contains a sample form, which you may choose to use to designate a patient advocate, you may use a form designed by an organization, you may hire a lawyer to draft the necessary documentation, or you may write out the document yourself. If you write the documentation yourself, make sure that it is legible. Under state law, you must sign the document, date it, and have it witnessed as described above. A person accepting the responsibility to act as a patient advocate must sign an acceptance to the designation document, which contains provisions required by statute.

22. What if there is a dispute as to how much durable power of attorney for health care should be carried out?

If there is a dispute as to whether your patient advocate is acting consistent with your best interest, the probate court may be petitioned to resolve the dispute. The court can remove a patient advocate who acts improperly in your behalf.

# Durable Power of Attorney for Health Care

I, \_\_\_\_\_ of \_\_\_\_\_, Michigan,  
(Name) (City)

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 \_\_\_\_\_, residing at \_\_\_\_\_,  
(Successor Patient Advocate) (Successor Patient Address)  
\_\_\_\_\_, to serve as my patient advocate.

With respect to my personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

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

- A. To have access to and control over my medical and other personal information.
- B. To employ and discharge physicians, nurses, therapists and 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. 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:

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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 to be treated as a Durable Power of Attorney and shall survive my disability or incapacity.

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

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

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(Signature)

(Date)

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(Social Security Number)

WITNESSES:

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

Names and Addresses of Witnesses:

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(Witness 1 Name)

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(Witness 1 Address)

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(Witness 1 Signature)

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(Witness 2 Name)

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(Witness 2 Address)

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(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 regard to the following forms of treatment:

*(Please check your choices)*

- |  |                        |
|--|------------------------|
| <input type="checkbox"/> I do want     | Cardiac Resuscitation  |
| <input type="checkbox"/> I do not want |                        |
| <input type="checkbox"/> I do want     | Mechanical Respiration |
| <input type="checkbox"/> I do not want |                        |
| <input type="checkbox"/> I do want     | Feeding Tubes          |
| <input type="checkbox"/> I do not want |                        |
| <input type="checkbox"/> I do want     | Kidney Dialysis        |
| <input type="checkbox"/> I do not want |                        |
| <input type="checkbox"/> I do want     | Chemotherapy           |
| <input type="checkbox"/> I do not want |                        |
| <input type="checkbox"/> I do want     | Antibiotics            |
| <input type="checkbox"/> I do not want |                        |
| <input type="checkbox"/> I do want     | Intravenous Fluids     |
| <input type="checkbox"/> I do not want |                        |

*(For additional instructions add sheet(s) as necessary.)*

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

\_\_\_\_\_

(Signature)

(Date)

\_\_\_\_\_

(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 provided 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, would 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 patient'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 has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and 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)

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## QUESTIONS AND ANSWERS

### Organ Donations

1. How can I be assured that my donation decision will be carried out?

First, discuss your wishes with your family because your next-of-kin will be requested to give consent for donation at the time of your death. Then sign a donor card or driver license sticker in the presence of two witnesses and carry it with you at all times.

2. Can the next-of-kin consent to a donation if the deceased family member has not signed either a donor card or a driver's license?

Yes. The Public Health Code provides for this opportunity.

3. Can my donation decision be included in a will?

Yes. However, since organ donations must occur promptly, this will normally be ineffective because wills are rarely read, let alone probated, until long after the time for the organ donation has passed. Still, the time of making a will may be a good time to discuss donation with family members. The discussion with your next-of-kin is most important.

4. Who can be a donor?

Almost anyone. Poor health, poor eyesight and age do not prohibit you from becoming a donor. However, some of these factors do influence the likelihood of the tissues being suitable for transplant. Organs and tissues that cannot be used for transplants, however, can often be used for research to help scientists find cures or better treatments for serious illness.

5. Will donation affect my funeral arrangements?

No. The donation is performed within hours after death, so funeral arrangements may proceed as planned. Removal of organs leaves no visible signs that would interfere with a normal open casket viewing.

6. Will my family pay or receive any fees for donation?

No. It is illegal to buy or sell human eyes, organs, and tissues.

7. Will the quality of medical treatment be affected if one is a known donor?

Strict laws protect the potential donor. Legal guidelines must be followed before death can be certified. The physician certifying a patient's death cannot be involved in any way with the donation or with the transplant.

8. How can I obtain more information regarding organ, tissue and eye donation?

Contact the Transplantation Society of Michigan at 1-800-482-4881 for a donor card or more information about this life-saving decision. Contact the Michigan Eye Bank at 1-800-247-7250 for questions specific to eye donation. ■

**DONATION FORM**

*fold and mail to: Transplantation Society of Michigan • 2203 Plat Road • Ann Arbor, MI 48104*

*Questions? Please feel free to call: 1-800-247-7250 or 1-800-482-4881*

**Uniform Donor Card**

of \_\_\_\_\_  
*(Print or type name of donor)*

In the hope that I may help others, I hereby make this anatomical gift if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give (a) \_\_\_\_\_ any needed organs or physical parts

(b) \_\_\_\_\_ only the following organs or physical parts:

\_\_\_\_\_  
*(Specify the organ(s) or physical part(s) )*

for the purposes of transplantation, therapy, or medical research or education;

(c) \_\_\_\_\_ my body for anatomical study if needed.

Limitations or special wishes, if any: \_\_\_\_\_

Signed by the donor and the following 2 witnesses in the presence of each other:

\_\_\_\_\_  
*Signature of donor*

\_\_\_\_\_  
*Date of birth of donor*

\_\_\_\_\_  
*Date signed*

\_\_\_\_\_  
*City and state*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Witness*