

MAKING HEALTH CARE DECISIONS IN NORTH DAKOTA

A SUMMARY OF NORTH DAKOTA LAW REGARDING

LIVING WILLS

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

AND

THE INFORMED HEALTH CARE CONSENT LAW

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INTRODUCTION

The Patient Self-Determination Act is a federal law that requires health care providers to educate their patients and the community on issues related to advance directives (living wills and durable power of attorney for health care).

It requires hospitals, nursing facilities, hospices, home health agencies, and HMOs certified by Medicare and Medicaid to furnish written information so that patients have the opportunity to express their wishes regarding the use or refusal of medical care, including life-prolonging treatment, nutrition, and hydration.

The federal law takes no stand on what decisions persons should make. It does not require persons to execute either a living will or durable power of attorney, or other "advance directive."

This booklet was developed by the Aging Services Division of the North Dakota Department of Human Services to provide you a written summary of North Dakota law regarding advance directives and health care decision-making authority. It is not intended to provide specific legal advice regarding these matters, and therefore any specific questions should be addressed to an attorney.

YOUR RIGHT TO MAKE YOUR MEDICAL DECISIONS

As a competent adult, you have the right to control decisions about your own health care. You have the right to accept or to refuse any treatment, service, or procedure used to diagnose, treat, or care for your physical or mental condition.

You have the right to make your own health care decisions as long as you have the ability to understand:

- 1. Your medical condition; and**
- 2. The benefits, risks, and burdens of a particular course of treatment and care and its alternatives.**

Your right to decide includes the right to control the use of medical technology in regard to your health care. Part of your right to make your own medical decisions is your right to decide, based upon your values, the extent to which medical technology should be used and under what circumstances.

Your right to decide also includes the right to make decisions regarding the artificial giving of food and water (nutrition and hydration).

TO EXERCISE YOUR RIGHT TO MAKE YOUR OWN MEDICAL DECISIONS, YOU SHOULD DO THE FOLLOWING:

- 1. Make certain you understand your medical treatment options. If you do not understand something or need more information, ask your health care provider(s). You have the right to an explanation in terms that you actually understand.**
- 2. If you have ethical or moral concerns about your decisions, you should speak to your minister, rabbi, or other advisor, or perhaps, members of your family or a close friend.**
- 3. Discuss your desires with your doctor or health care provider. Make sure that your health care provider understands what you want in the event you are unable to make your own medical decisions.**

There may come a time when, due to your mental or physical condition, you may be unable to make your own health care decisions. Then your health care providers will look to any prior written advance directives or to family members to make decisions on your behalf. A determination that you are unable to make your own health care decisions must be made by a doctor.

Two forms of advance directives have been approved by the North Dakota legislature: A LIVING WILL and A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. In addition, North Dakota also has an INFORMED HEALTH CARE CONSENT LAW which authorizes other persons to make health care decisions for you if

you are either a minor or are unable to make your own medical decisions.

LIVING WILLS

The North Dakota law regarding "living wills" is Chapter 23-06.4 of the North Dakota Century Code.

A living will is a legal document which permits you to decide whether you want life-prolonging treatment or nutrition and hydration (the artificial giving of food and water) started or continued if you are unable to make those decisions yourself and you have a terminal, incurable condition which will result in imminent death. In North Dakota, a living will is called a **DECLARATION RELATING TO THE USE OF LIFE-PROLONGING TREATMENT.**

Your decision to complete a living will is personal and should be based upon your individual values and beliefs.

TO COMPLETE A LIVING WILL:

- 1. Use the appropriate form. The law includes an approved form (pages 26-29) and requires that your declaration, or living will, be substantially in the same form. However, you may add additional specific directives to your living will.**
- 2. Make certain you sign your living will and have it properly verified either by a notary public or by two witnesses who are at least eighteen years of age. At least one witness must not be a health care provider providing direct care to you.**
- 3. Give a copy of your living will to your doctor and any other health care providers such as, your hospital, nursing facility, hospice, or home health agency. In addition, you may want to give copies of your living will to other persons such as, close family members and your attorney, if you have one.**

QUESTIONS AND ANSWERS - LIVING WILLS

This section includes a number of commonly asked questions and their answers regarding Living Wills.

1. WHAT IS A LIVING WILL?

A living will is a written declaration in which you state your wishes regarding the use, withholding or withdrawal of life-prolonging treatment and nutrition and hydration if you have a terminal condition and are unable to make such decisions yourself.

2. WHAT IS LIFE-PROLONGING TREATMENT?

Life-prolonging treatment is any medical procedure or treatment that serves only to extend the process of dying if you are in a terminal condition. It is usually used to refer to artificial support for breathing, heart, and kidney function.

Under North Dakota law, it does NOT include:

- 1) giving nutrition or hydration;
- 2) easing pain or providing comfort; or
- 3) emergency, pre-hospital treatment.

3. WHAT IS A TERMINAL CONDITION?

An incurable or irreversible condition that, without life-prolonging treatment, will result, in your doctor's opinion, in imminent death .

4. CAN I INCLUDE DIRECTIONS AUTHORIZING THE WITHDRAWAL OR WITHHOLDING OF NUTRITION AND/OR HYDRATION IN MY LIVING WILL?

Yes. North Dakota law requires that nutrition and hydration or both must be withdrawn, withheld, or administered if the patient has previously declared IN WRITING the patient's desire that nutrition or hydration be withdrawn, withheld, or administered.

5. WHEN DOES A LIVING WILL TAKE EFFECT?

A living will takes effect when all four of the following occur:

- 1) you have executed a written living will in accordance with state law;**
- 2) your doctor and another doctor determine that you are in a "terminal condition";**
- 3) your doctor and another doctor determine that you are no longer able to make decisions regarding life-prolonging treatment; and**
- 4) you "communicate" your living will to your doctor by providing him or her a copy.**

6. WHO CAN MAKE A LIVING WILL?

Any competent person 18 years of age or older.

7. DOES A LIVING WILL NEED TO BE WITNESSED OR NOTARIZED?

A living will must contain verification of your signature either by a notary public or two witnesses who are at least eighteen years of age.

The witnesses to your living will cannot be:

- 1) your spouse;**
- 2) related to you by blood, marriage, or adoption;**
- 3) entitled to receive property under your will or by deed;**
- 4) claimants to any portion of your estate;**

- 5) directly financially responsible for your medical care; or
- 6) the doctors primarily responsible for your care.

8. HOW DO I KNOW THAT MY WISHES WILL BE CARRIED OUT?

Your doctor or health care provider is responsible for ensuring that your wishes are carried out. If your doctor or health care provider is unwilling to comply with your wishes, then he or she must take all reasonable steps to transfer your care to another doctor or health care provider who is willing to comply.

9. CAN I REVOKE MY LIVING WILL?

Yes. As long as you remain competent you can revoke your living will in any one of three ways:

- 1) by signing and dating a piece of paper stating you revoke your living will;
- 2) by physically destroying the living will or having someone else destroy it in your presence and with your permission or instruction; or
- 3) by stating orally that you wish to revoke the living will.

Your revocation is effective as soon as you communicate it to your doctor or health care provider, and must be made a part of your medical record.

10. CAN I BE REQUIRED TO SIGN A LIVING WILL?

No. No one may discriminate against you because you have or have not signed a living will.

11. AFTER I HAVE SIGNED A LIVING WILL, WHAT SHOULD I DO WITH IT?

It is a good idea to talk about your living will with your doctor and other health care provider, and your family, since your doctor will probably consult them in the event you are unable

to make your own health care decisions. Copies should be given to your doctor, any other health care provider, and members of your family.

12. **WHAT IF I HAVE A LIVING WILL WHICH WAS WRITTEN YEARS AGO?**

The statute governing living wills in North Dakota was made effective on July 10, 1989. If you signed a living will before July 10, 1989, it will remain in effect if it complies with the intent of North Dakota's living will statute.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The North Dakota law regarding durable power of attorney for health care is Chapter 23-06.5 of the North Dakota Century Code.

A durable power of attorney for health care is a legal document that permits you (the PRINCIPAL) to appoint someone else to make medical decisions for you if you lack the capacity to make health care decisions yourself, and to provide instructions as to your specific health care decisions. The person you designate to act as your representative is called your AGENT. Certain people are not allowed to act as your Agent.

The words “FOR HEALTH CARE” distinguish a special durable power of attorney for health care from a general durable power of attorney, used to permit an agent to conduct your business affairs. If you signed such a general durable power of attorney prior to July 17, 1991, your Agent will not have authority to make your health care decisions unless the general durable power of attorney gives your Agent specific authority to make health care decisions.

TO COMPLETE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE:

- 1. Use the appropriate form. The law includes an approved form (pages 30-40).**
- 2. Carefully select the person you want to act as your Agent and/or Alternate Agent. Discuss the role of your Agent and/or Alternate Agent with the persons you select and ensure they are willing to accept the responsibilities.**
- 3. Tell your Agent what kinds of health care decisions you want your Agent to make on your behalf. You should also consider any written instructions you might wish to include to limit the Agent’s authority or to provide guidance for your Agent.**

- 4. Sign your durable power of attorney in front of a notary public or two appropriate witnesses as required under state law. Be aware that certain people cannot act as a witness. Note that there are special requirements that apply if you are a resident of a nursing home or patient at a hospital. (See sections 17 and 18 below or North Dakota Century Code section 23-06.5-10).**
- 5. You and your Agent and Alternate Agent must sign your durable power of attorney for health care indicating they accept appointment and are willing to serve.**
- 6. After signing a durable power of attorney for health care, distribute copies of the document. You may choose to give the original to your Agent or put it in a place where it is accessible to your Agent or alternate Agent. It is recommended you also provide copies to your physician, other health care providers, and family members.**

QUESTIONS AND ANSWERS - DURABLE POWER **OF** **ATTORNEY FOR HEALTH CARE**

This section includes a number of commonly asked questions and their answers regarding Durable Power of Attorney for Health Care.

1. WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

It is a legal document that allows you (the "Principal") to authorize someone of your own choosing (your "Agent") to make health care decisions for you if you become unable to make those decisions for yourself, and to provide instruction as to your specific wishes with regard to health care decisions.

2. HOW IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DIFFERENT THAN A LIVING WILL?

A living will declares your intent regarding the use or withholding of life-prolonging treatment, nutrition, and hydration if you become terminally ill. A durable power of attorney for health care authorizes an Agent to make health care decisions for you if you are unable to make these decisions yourself, even if your condition is not terminal.

You can use a durable power of attorney for health care to give specific instructions to your Agent, to request all appropriate care, or to limit the type of care. The durable power of attorney for health care allows your Agent to respond to situations that you are unable to anticipate and to make decisions for you on an informed basis.

3. DO I NEED A LIVING WILL IF I HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

If you choose, you may provide specific instructions to your Agent in a durable power of attorney for health care to

withhold, withdraw, or use life-prolonging treatment, nutrition, and hydration in the event you should have an incurable disease.

For example, in paragraph 4 of your durable power of attorney for health care, you could direct your Agent to either use, withhold, or withdraw life-prolonging treatment, nutrition, or hydration in the event you would have an incurable condition caused by injury, disease, or illness. This would make a living will unnecessary.

4. WHAT IF I SIGNED A GENERAL DURABLE POWER OF ATTORNEY WHICH INCLUDES HEALTH CARE PROVISIONS?

The statute specifically governing the durable power of attorney for health care was made effective on July 17, 1991. If you signed a general durable power of attorney before that date, and it contained health care instructions or wishes, it will be sufficient.

5. WHO CAN MAKE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

Any competent person 18 years of age or older.

6. CAN I SIGN A DURABLE POWER OF ATTORNEY FOR HEALTH CARE IF I HAVE ALREADY SIGNED A LIVING WILL?

Yes. You may sign both a durable power of attorney for health care and a living will although it is not necessary to do so. A durable power of attorney for health care is more flexible than a living will and covers a wider range of circumstances than a living will. Signing a durable power of attorney for health care does not cancel out your living will, but if there are any differences between the two documents, the one you signed most recently will control.

7. CAN I BE REQUIRED TO SIGN A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

No. No one may discriminate against you because you have or have not signed a durable power of attorney for health care.

8. WHAT DOES “HEALTH CARE DECISION” MEAN?

It means to consent to, refuse to consent to, withdraw consent to, or request any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

9. WHAT IF I HAVE QUESTIONS ABOUT ANY MEDICAL TREATMENT OR MEDICAL TERMS?

You should talk to your doctor or some other medical professional who can tell you about various kinds of medical treatments, services, procedures, or life-sustaining care.

10. WHOM SHOULD I APPOINT AS MY AGENT?

Your Agent should be someone whom you know and trust, who knows how you feel about medical treatment, who understands your beliefs and values, and who is willing to carry out your wishes.

Note however that certain people cannot act as your Agent.

These people are:

- 1) your health care provider;**
- 2) a nonrelative who is employed by your health care provider;**
- 3) your long-term care services provider; or**
- 4) a nonrelative who is employed by your long-term care services provider.**

11. SHOULD I APPOINT AN ALTERNATE AGENT?

The appointment of an Alternate Agent is not required, but it is a good safeguard if something should happen to your original Agent.

12. WHAT KIND OF HEALTH CARE DECISIONS CAN MY AGENT MAKE FOR ME?

Your Agent will have the authority to make any and all health care decisions on your behalf that you could make yourself, with two exceptions:

- 1) your Agent cannot make a decision if you limit his or her authority to make such a decision on your behalf; or**
- 2) your Agent cannot make a decision if the law prohibits him or her from making such a decision on your behalf.**

13. WHAT KIND OF INSTRUCTIONS CAN I GIVE MY AGENT?

You may give very general instructions or be quite specific. You are not required to give your Agent any instructions. If you do not give your Agent any instructions, your Agent will make decisions based upon your values as determined by your Agent. If your Agent is unable to determine what you would have decided, your Agent must make decisions based upon what he or she believes to be best for you under the circumstances.

14. WHAT ARE MY AGENT'S RESPONSIBILITIES IN CARRYING OUT MY WISHES?

Your Agent is required to follow your wishes as contained in your durable power of attorney for health care, your living will, if you have one, or as stated orally. If your wishes are unknown, your Agent is required to make health care decisions for you based on what he or she feels is in your best interest.

15. HOW DO I KNOW THAT MY DOCTOR OR HEALTH CARE PROVIDER WILL FOLLOW MY AGENT'S DECISIONS?

Your doctor and any other health care provider are bound to follow the directions of your Agent to the extent they are consistent with the law and your wishes.

If a health care provider has a moral or other conflict with a specific decision, and therefore finds it impossible to follow your instructions, the health care provider must inform your Agent and, if possible, you, of the conflict and then take all reasonable steps to transfer your care to a health care provider who will follow your Agent's instructions.

16. WHEN DOES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE BECOME EFFECTIVE?

The durable power of attorney for health care is effective when all of the following occur:

- 1) you have executed a durable power of attorney for health care according to state law requirements (e.g. in writing, signed, witnessed);
- 2) your Agent has accepted the position as Agent in writing;
and
- 3) your doctor has certified, in writing, that you lack the capacity to make health care decisions. You lack capacity to make health care decisions when you do not have the ability to understand and appreciate the nature and consequences of a health care decision, including the significant benefits and harms of proposed health care, or reasonable alternatives to that health care.

17. IF I AM A RESIDENT OF A LONG-TERM CARE FACILITY, ARE THERE ANY SPECIAL REQUIREMENTS?

Yes. If you are a resident of a nursing home or other long-term care facility at the time you sign a durable power of attorney for health care, it will not be effective unless (a) or (b) occurs:

- a. one of the following persons signs a statement affirming that they have explained the nature and effect of a durable power of attorney for health care to you:

- 1) a member of the clergy;
- 2) an attorney licensed to practice law in North Dakota;
- 3) a person designated by the Department of Human Services; or
- 4) a person designated by the district court in the county where the facility is located.

- b. you state in writing that you have read the explanation of a durable power of attorney for health care as provided in North Dakota Century Code Section 23-06.5-17 or a similar written explanation of the nature and effect of a durable power of attorney for health care.

18. IF I AM BEING ADMITTED TO OR AM A PATIENT IN A HOSPITAL, ARE THERE ANY SPECIAL REQUIREMENTS?

Yes. If you are being admitted to a hospital at the time you execute a durable power of attorney for health care, or are already a patient in a hospital, the durable power of attorney for health care will not be effective unless (a) or (b) occurs:

- a. one of the following people signs a statement affirming that they have explained the nature and effect of a durable power of attorney for health care to you:
 - 1) a person designated by the hospital; or
 - 2) an attorney licensed to practice law in North Dakota
- b. you sign a statement in which you assert that you have read the explanation of a durable power of attorney provided in North Dakota Century Code Section 23-06.5-17 or a similar written explanation of the nature and effect of a durable power of attorney for health care.

19. CAN I STILL MAKE MY OWN HEALTH CARE DECISIONS AFTER I HAVE SIGNED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

Yes. You will be able to make your own health care decisions as long as you are capable of doing so. Your Agent's authority starts only when your doctor certifies in writing that you do not have the capacity to make health care decisions.

20. WHERE SHOULD I KEEP MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

The original signed copy should be given to your Agent or you should keep it where it is immediately available to your Agent and your Alternate Agent, your doctor, and any other health care provider.

21. IS MY AGENT OR ALTERNATE AGENT LIABLE FOR MY HEALTH CARE COSTS?

No. The liability for the cost of your health care is the same as if you made the decision yourself.

22. CAN MY AGENT OR ALTERNATE AGENTS WITHDRAW?

Yes. An Agent or Alternate Agent may withdraw by giving you notice prior to the time you are determined to lack capacity to make health care decisions. After such time, your Agent or Alternate Agent may withdraw by giving notice to your doctor.

23. DOES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE NEED TO BE WITNESSED OR NOTARIZED?

You must sign a durable power of attorney for health care in the presence of a notary public or two witnesses.

At least one of the witnesses **CANNOT** be a health care or long-term care provider providing direct care to you or an employee of a health care or long-term care provider providing direct care to you.

The notary or any witness, may not be:

- 1) your Agent;
- 2) your Alternate Agent;
- 3) your spouse or heir;
- 4) a relative by blood, marriage, or adoption;
- 5) a person entitled to receive any part of your estate upon your death under a will or deed in existence or by operation of law; or
- 6) a person who, at the time you sign the durable power of attorney for health care, has any claim against your estate.
- 7) a person directly financially responsible for your medical care; or
- 8) your attending physician.

If you are physically unable to sign the durable power of attorney for health care yourself, you may have someone sign your name for you as long as they are signing your name in your presence and with your express direction.

24. WHEN DOES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE END?

An Agent's authority to make decisions on your behalf generally ends in five circumstances:

- 1) upon your death;
- 2) you regain capacity to make your own health care decisions;
- 3) if your Agent withdraws;
- 4) if you revoke the durable power of attorney for health care; or
- 5) if a court takes away your Agent's power to make health care decisions for you.

25. HOW DO I REVOKE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

If you want to revoke your durable power of attorney for health care, you may do it in any one of three ways:

- 1) write a new one(this will automatically revoke the old one):

- 2) notify your Agent or a doctor, long-term care services provider, or health care services provider, orally or in writing of your specific intent to revoke;
- 3) by performing any other act which demonstrates your specific intent to revoke the power.

26. CAN I INSTRUCT MY AGENT TO WITHHOLD OR WITHDRAW NUTRITION AND/OR HYDRATION?

Yes. Nutrition or hydration or both must be withdrawn, withheld, or administered if you have previously declared your wishes in writing.

27. CAN I AUTHORIZE MY AGENT TO DONATE MY BODY ORGANS?

Yes. If you desire to donate your body organs after your death, the following clause could be inserted into paragraph 4(b) of the statutory form:

“I authorize, at the time of my death, all or part of my body to be used by any hospital, physician, surgeon, or procurement organization for transplantation, therapy, medical and dental education, research for advancement of medical or dental science.”

INFORMED HEALTH CARE CONSENT LAW

This law can be found in Section 23-12-13 of the North Dakota Century Code.

THE INFORMED HEALTH CARE CONSENT LAW establishes a priority list of persons who are authorized to provide consent for minors or persons who are incapacitated and, therefore, unable to make or communicate their own medical decisions. This law is particularly useful when a person does not have a living will or durable power of attorney for health care.

The law applies to two groups of people: minors, and adults who are "incapacitated." You are considered a "minor" if you are under age eighteen. You are considered "incapacitated" when you are unable to make or communicate responsible decisions regarding personal matters such as medical treatment.

This law requires that a person who is authorized to provide informed consent on your behalf must first determine that you would have consented to the proposed health care if you were able. If such a determination cannot be made, the authorized person may consent only after determining that the proposed health care is in your best interests.

QUESTIONS AND ANSWERS - INFORMED **HEALTH CARE** **CONSENT LAW**

This section includes a number of commonly asked questions and their answers regarding Informed Health Care Consent Law.

1. **IF I HAVE A SIGNED LIVING WILL, DOES THIS LAW APPLY?**

Possibly. If your living will is ambiguous or does not address a specific health care decision, this law will determine who may make such a decision for you.

2. **IF I HAVE A SIGNED DURABLE POWER OF ATTORNEY FOR HEALTH CARE, WILL THIS LAW APPLY?**

Possibly. There is an interaction between the law applicable to the durable power of attorney for health care and the Informed Health Care Consent law. The interaction arises from the fact that the Informed Health Care Consent law provides that any person you give authority to act as your Agent under a durable power of attorney for health care has highest priority to make health care decisions for you if you become incapacitated.

3. **AT WHAT POINT WOULD THE LAW AUTHORIZE ANOTHER PERSON TO MAKE MY HEALTH CARE DECISIONS?**

A doctor must first determine that you are unable to make or communicate responsible health care decisions before anyone would be authorized to make health care decisions for you.

4. **WHO IS AUTHORIZED BY THIS LAW TO MAKE HEALTH CARE DECISIONS?**

The law authorizes the persons in the following categories, in the order listed, to make your health care decisions if you are either a minor or if your doctor determines that you are unable to make or communicate responsible decisions about your health care:

- A. Your Agent under a durable power of attorney which gives the Agent authority to make health care decisions for you, unless a court specifically authorizes a guardian to make medical decisions for you;
- B. Your court-appointed guardian or custodian, if any;
- C. Your spouse, if he or she has maintained significant contacts with you;
- D. Any of your children who are at least eighteen years old and have maintained significant contacts with you;
- E. Your parents, including a stepparent, who has maintained significant contacts with you;
- F. Your adult brothers and sisters who have maintained significant contacts with you;
- G. Your grandparents who have maintained significant contacts with you;
- H. Your grandchildren who are at least eighteen years old and who have maintained significant contacts with you; or
- I. A close relative or friend who is at least eighteen years of age and who has maintained significant contacts with you.

5. WHAT HAPPENS IF A PERSON IN A HIGHER CATEGORY REFUSES TO CONSENT TO THE PROPOSED HEALTH CARE?

No one in a lower category may provide consent to the proposed health care if someone in a higher category has refused to consent.

6. IS IT NECESSARY FOR EVERYONE IN A PARTICULAR CATEGORY TO CONSENT TO THE PROPOSED HEALTH CARE?

No. A physician seeking informed consent for proposed health care must only receive the consent of one competent person in the highest ranking category.

7. ARE THERE ANY GUIDELINES WHICH MUST BE FOLLOWED BY THE PERSON AUTHORIZED TO GIVE CONSENT TO HEALTH CARE?

Yes. Before giving consent, an authorized person must determine that you would have consented to such health care if you were able to do so. If the authorized person is unable to make this determination, he or she may only consent to the proposed health care if he or she feels the health care is in your best interests.

8. ARE THERE ANY HEALTH CARE DECISIONS THAT THE LAW DOES NOT PERMIT ANYONE TO MAKE?

Yes. No one may consent for you to receive any of the following treatments or procedures:

- 1) sterilization;**
- 2) abortion;**
- 3) psychosurgery; or**
- 4) admission to a state mental health facility (state hospital) for a period of more than forty-five days, unless a court order is obtained.**

9. WHAT IF I OR SOMEONE INTERESTED IN MY WELFARE OBJECTS TO MY DOCTOR'S CONCLUSION THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS?

If you or someone interested in your welfare objects to a doctor's decision that you are unable to make or communicate health care decisions, a court hearing must be held to determine whether you are able to make your own health care decisions.

FORMS APPENDIX

LIVING WILLS

Declaration Regarding Life-Prolonging Treatment and Nutrition and Hydration

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

DECLARATION RELATING TO THE USE OF LIFE-PROLONGING TREATMENT

This is an important legal document which permits you to make decisions now regarding the use, withholding, or withdrawal of life-prolonging treatment, nutrition (food), and hydration (water).

This statement of your wishes will be used by others if you are terminally ill and your death is imminent and you are not able to make these health care decisions yourself.

The intent of this document is to provide an easy-to-use living will form for those who wish to use it.

According to the legal requirements, please place your initials in the appropriate blank spaces to indicate your choices on the form. Please do not use an “x” or check mark.

This form has been developed with the cooperation and assistance of representatives of the organizations listed below. These organizations do not all encourage use of the living will. However, all these organizations urge you to consider completing a durable power of attorney for health care form. The durable power of attorney enables you to designate the person you want to make your health care decisions when you are no longer able to make these decisions yourself.

The North Dakota Hospice Organization, the North Dakota Judicial System, the North Dakota Nurses Association, the North Dakota

Right to Life, the North Dakota Department of Human Services, the North Dakota State Bar Association, the North Dakota Catholic Conference, the North Dakota Medical Association, the North Dakota Hospital Association, the North Dakota Lutheran Social Services, and the North Dakota Long-Term Care Association.

DECLARATION RELATING TO USE OF LIFE-PROLONGING TREATMENT

This is an important legal document about life-prolonging treatment and nutrition and hydration. This document becomes effective only when you are terminally ill.

I declare on _____(month, day, year)

A. I have made the following decision concerning life-prolonging treatment (initial 1, 2, or 3):

(1) (_____) I direct that life-prolonging treatment be withheld or withdrawn and that I be permitted to die naturally if two physicians certify that:

(a) I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death;

(b) The application of life-prolonging treatment would serve only to artificially prolong the process of my dying; and

(c) I am not pregnant.

It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of that refusal, which is death.

(2) (_____) I direct that life-prolonging treatment, which could extend my life, be used if two physicians certify that I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death. It is my intention that this declaration be honored by my

family and physicians as the final expression of my legal right to direct that medical or surgical treatment be provided.

(3) (_____) I make no statement concerning life-prolonging treatment.

B. I have made the following decision concerning the administration of nutrition when my death is imminent (initial only one statement):

(1) (_____) I wish to receive nutrition.

(2) (_____) I wish to receive nutrition unless I cannot physically assimilate nutrition, nutrition would be physically harmful or would cause unreasonable physical pain, or nutrition would only prolong the process of my dying.

(3) (_____) I do not wish to receive nutrition.

(4) (_____) I make no statement concerning the administration of nutrition.

C. I have made the following decision concerning the administration of hydration when my death is imminent (initial only one statement):

(1) (_____) I wish to receive hydration.

(2) (_____) I wish to receive hydration unless I cannot physically assimilate hydration, hydration would be physically harmful or would cause unreasonable physical pain, or hydration would only prolong the process of my dying.

(3) (_____) I do not wish to receive hydration.

(4) (_____) I make no statement concerning the administration of hydration.

- D. Concerning the administration of nutrition and hydration, I understand that if I make no statement about nutrition or hydration, my attending physician may withhold or withdraw nutrition or hydration if the physician determines that I cannot physically assimilate nutrition or hydration or that nutrition or hydration would be physically harmful or would cause unreasonable physical pain.
- E. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration is not effective during the course of my pregnancy.
- F. I understand the importance of this declaration, I am voluntarily signing this declaration, I am at least eighteen years of age, and I am emotionally and mentally competent to make this declaration.
- G. I understand that I may revoke this declaration at any time.

Signed _____

City, County, and State of Residence _____

Choose either option one or option two below:

H. Option 1: Notary Public (no witnesses are necessary if a notary public verifies the declarant's signature).

In my presence on _____ (date),
_____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

Signature of Notary Public
My commission expires: _____

I. Option 2: Two Witnesses (no notary public is necessary if two witnesses verify the declarant's signature).

Witness One:

(1) In my presence on _____ (date),
_____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care or long-term care provider or an employee of a health care or long-term care provider giving direct care to the declarant, I must initial this box:

I certify that the information in (1) through (3) is true and correct.

Signature of witness one

Address

Witness Two:

(1) In my presence on _____ (date),
_____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care or long-term care provider or an employee of a health care or long-term care provider giving direct care to the declarant, I must initial this box:

I certify that the information in (1) through (3) is true and correct.

Signature of witness two

Address

A physician or other health care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record, and if unwilling to comply with the declaration, promptly so advise the declarant.

**STATUTORY FORM DURABLE POWER OF
ATTORNEY FOR
HEALTH CARE
WARNING TO PERSON EXECUTING THIS
DOCUMENT**

This is an important legal document that is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen years of age for this document to be legally valid and binding.

This document gives the person you designate as your Agent (the attorney in fact) the power to make health care decisions for you. Your Agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your Agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you give informed consent with respect to the particular decision.

This document gives your Agent authority to request, consent to, refuse to consent to, or to withdraw consent for any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition if you are unable to do so yourself. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your Agent to make health care decisions for you if your Agent authorizes anything that is illegal; acts contrary to your known desires; or where your desires are not known, does anything that is clearly contrary to your best interest.

Unless you specify a specific period, this power will exist until you revoke it. Your Agent's power and authority ceases upon your death. You have the right to revoke the authority of your Agent by notifying your Agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation. Your Agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your Agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your Agent and alternate Agents, if any, or give each of them an executed copy of this document. You should give your doctor an executed copy of this document.

1. DESIGNATION OF HEALTH CARE AGENT

(insert your name and address)

do hereby designate and appoint:

(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you)

None of the following may be designated as your agent: your treating health care provider, a nonrelative employee of your treating health care provideoperator of a long-term care

facility, or a nonrelative employee of an operator of a long-term care facility) as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, “health care decision” means consent, refusal of consent or withdrawal of consent, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition.

2. **CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.** By this document I intend to create a durable power of attorney for health care.
3. **GENERAL STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures. (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 below. You can indicate your desires by including a statement of your desires in the same paragraph.)
4. **STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.** (Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given

your agent by this document, you should state the limits in the space provided below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.) In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

- a. **Statement of desires concerning life-prolonging care, treatment, services, and procedures:**

- b. **Additional statement of desires, special provisions, and limitations regarding health care decisions:**

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.) If you wish to make a gift of any bodily organs you may do so pursuant to North Dakota Century Code Chapter 23-06.2, the Uniform Anatomical Gift Act.

- 5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:**

- a. **Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.**

- b. Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- c. Consent to the disclosure of this information. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 above.)

6. **SIGNING DOCUMENTS, WAIVERS, AND RELEASES.** Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

- a. Documents titled or purporting to be a “Refusal to Permit Treatment” and “Leaving Hospital Against Medical Advice”.
- b. Any necessary waiver or release from liability required by a hospital or physician.

7. **DURATION.** (Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.) This durable power of attorney for health care expires on

_____.
(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

8. **DESIGNATION OF ALTERNATE AGENTS.** (You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, in the event that the agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved. Your agent may withdraw whether or not you are capable of designating another agent.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make health care decisions for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

a. First Alternate

Agent: _____

(Insert name, address, and telephone number of first alternate agent.)

B. Second Alternate

Agent: _____

(Insert name, address, and telephone number of second alternate agent.)

9. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney For

Health Care on _____
(Date)

at _____, ND.
(City)

(You sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

NOTARY PUBLIC OR STATEMENT OF WITNESSES

This document must be notarized or witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider providing your care. At least one witness to the execution of the document must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care. None of the following may be used as a witness or notary:

- 1. A person you designate as your agent or alternate agent;**
- 2. Your spouse or heir;**
- 3. A person related to you by blood, marriage, or adoption;**
- 4. A person entitled to inherit any part of your estate upon your death under a will or deed in existence or by operation of law;**
- 5. A person who has, at the time of executing this document, any claim against your estate.**
- 6. A person directly financially responsible for your medical care;**
or
- 7. Your attending physician.**

Choose either option one or option two below:

H. Option 1: Notary Public (no witnesses are necessary if a notary public verifies the declarant's signature).

**In my presence on _____ (date),
_____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.**

Signature of Notary Public
My commission expires: _____

I. Option 2: Two Witnesses (no notary public is necessary if two witnesses verify the declarant's signature).

Witness One:

**(1) In my presence on _____ (date),
_____ (name of declarant) acknowledged the
declarant's signature on this document or acknowledged that the
declarant directed the person signing this document to sign on the
declarant's behalf.**

(2) I am at least eighteen years of age.

**(3) If I am a health care or long-term care provider or an employee
of a health care or long-term care provider giving direct care to the
declarant, I must initial this box: [_____]**

I certify that the information in (1) through (3) is true and correct.

Signature of witness one

Address

Witness Two:

**(1) In my presence on _____ (date),
_____ (name of declarant) acknowledged the
declarant's signature on this document or acknowledged that the
declarant directed the person signing this document to sign on the
declarant's behalf.**

(2) I am at least eighteen years of age.

**(3) If I am a health care or long-term care provider or an employee
of a health care or long-term care provider giving direct care to the
declarant, I must initial this box: [_____]**

I certify that the information in (1) through (3) is true and correct.

Signature of witness two

Address

10. ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY.
I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the Principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the Principal only if the Principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the Principal may revoke this power of attorney at any time in any manner.

If I choose to withdraw during the time the Principal is competent I must notify the Principal of my decision. If I choose to withdraw when the Principal is incapable of making the Principal's health care decision, I must notify the Principal's physician.

(Signature of agent/date)

(Signature of alternate agent/date)

(Signature of second alternate agent/date)

PRINCIPAL'S STATEMENT

I have read the statutory explanation of the nature and effect of a Durable Power of Attorney for Health Care that is attached to my Durable Power of Attorney for Health Care dated _____.

Dated this _____ day of _____,
19____.

(Signature of Principal)

**STATEMENT AFFIRMING EXPLANATION OF THE
NATURE AND EFFECT OF A
DURABLE POWER OF ATTORNEY FOR HEALTH
CARE
TO RESIDENT OF LONG-TERM CARE FACILITY**

I have explained the nature and effect of a Durable Power of Attorney for Health Care to:

(name of Principal)

who signed this document as the Principal and who is a resident of

(name of facility)

a long-term care facility located in the City of

_____,
_____, County, North Dakota.

I am (check one of the following):

- A recognized member of the clergy.
- An attorney licensed to practice law in North Dakota.
- A person designated by the County Court for the County in which the above named long-term care facility is located.
- A person designated by the North Dakota Department of Human Services.

Dated this _____ day of _____,
19_____.

(Signature)

NOTE: Either this statement or the Principal's statement must be completed if the Principal is a resident of a long-term care facility at the time he or she signs a Durable Power of Attorney for Health Care.

**STATEMENT AFFIRMING EXPLANATION OF THE
NATURE AND EFFECT OF A DURABLE POWER
OF ATTORNEY FOR HEALTH CARE TO A
HOSPITAL PATIENT**

I have explained the nature and effect of a Durable Power of Attorney for Health Care to

(name of Principal)

who signed it as the Principal and who is a patient or in the process of being admitted to

_____ hospital.

I am (check one of the following):

- An attorney licensed to practice law in North Dakota.
- A person designated by this hospital to explain the nature and effect of a Durable Power of Attorney for Health Care to patients or persons who are in the process of being admitted to this hospital.

Dated this _____ day of _____, 19_____.

(Signature)

NOTE: Either this statement or the Principal's statement must be completed if the Principal is a hospital patient or in the process of being admitted to a hospital when the Durable Power of Attorney for Health Care is signed.

