Advance Health Care Directive

of

_____

This form was developed by the Committee on Law and the Elderly of the Delaware Bar Association and approved for use by the Office of the Attorney General of the State of Delaware.

GENERAL INSTRUCTIONS

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You should read this form carefully before filling it in. You should fill it in completely. If there are health care decisions you do not want to make, you should strike the wording of that decision rather than leave it blank. You may not change the qualifications for witnesses or agents, even if you cross out the wording. You should write legibly.

After you have filled out the form completely, you should sign the form before a notary public. Although signing before a notary public is not legally required, it is advisable. It is advisable because the notary, as well as your witnesses, can testify as to your competence when you sign the directive, if your competence becomes an issue. Notaries, who are registered with the State, are often easier to locate later than witnesses.

You should retain your original Advance Health care Directive, and give copies to your doctor, agent, spouse, family members, and close friends, if you desire. You should explain to each person who receives a copy of your health care directive what choices you made on the form, and why. This will help if, while you lack competence, there arises a need to make a health care decision that is not explicitly set forth on your advance health care directive form.

This form does not contain all of the types of health care decisions you are legally entitled to make. For example, the form does not give you the opportunity to nominate a guardian, in the event you become incompetent and need one. Also, the form does not give you the opportunity to designate a primary care physician, or another person, to certify that you lack the capacity to make your own decisions on health care. Finally, the form does not include a provision that accommodates a person's religious or moral beliefs. If you would like to exercise these options, you should talk to an attorney. If anything on the form conflicts with your religious beliefs, you should contact your clergy.

PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

If you are an adult who is mentally competent, you have the right to accept or refuse medical or surgical treatment, if such refusal is not contrary to existing public health laws. You may give advance instructions for medical or surgical treatment that you want or do not want. These instructions will become effective if you lose the capacity to accept or refuse medical or surgical treatment. You may limit your instructions to take effect only if you are in a specified medical condition. If you give an instruction that you do not want your life prolonged, that instruction will only take effect if you are in a "qualifying condition." A "qualifying condition" is either a terminal condition or permanent unconsciousness.

If you want to give instructions to accept or refuse medical or surgical treatment, you should fill in the spaces on the following page. You may cross out any wording you do not want.

A. END OF LIFE INSTRUCTIONS

1. Choice To Prolong Life

_____I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

2. Choice Not To Prolong Life

I do not want my life to be prolonged if (please check all that apply)

____ (i) I have a terminal condition (an incurable condition from which there is no reasonable medical expectation of recovery and which will cause my death, regardless of the use of life-sustaining treatment). In this case, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____
_____		

_____ (ii) I become permanently unconscious (a medical condition that has existed at least four (4) weeks and has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma) and regarding the following, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____
_____		

B. RELIEF FROM PAIN: Whether I choose A.1 or A.2, or neither, I direct that in all cases I be given all medically appropriate care necessary to make me comfortable and alleviate pain.

C. OTHER MEDICAL INSTRUCTION: If you wish to add to the instructions you have given above, you may do so here.

_____

_____

(use additional sheets if necessary)

PART II: POWER OF ATTORNEY FOR HEALTH CARE

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Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions. You may appoint an alternate agent to make health care decisions for you if your first agent is not willing, able and reasonably available to make decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care.

If you wish to appoint an agent to make health care decisions for you under these circumstances and conditions, you must fill out the section below. You may cross out any wording you do not want.

A. DESIGNATION OF AGENT: I designate _____ as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available, to make health care decisions for me, then I designate _____ _____ as my agent to make health care decisions for me.

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

_____
(name of individual you choose as alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

B. AGENT'S AUTHORITY: I grant to my agent full authority to make decisions for me regarding my health care; provided that, in exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function;

2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;

4. To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;

5. To hire and fire medical, social service, and other support personnel responsible for my care; and

6. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.

C. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

D. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part I of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

PART III. ANATOMICAL GIFT DECLARATION (Optional)

I hereby make the following anatomical gift(s) to take effect upon my death. The marks in the appropriate squares and words filled into the blanks below indicate my desires:

I give [ ] my body; [ ] any needed organs or parts;
[ ] the following organs or parts _____

to [ ] the physician in attendance at my death; [ ] the hospital in which I die;
[ ] the following named physician, hospital, storage bank or other medical institution
_____

for the following purpose(s):
[ ] any purpose authorized by law; [ ] transplantation;
[ ] therapy; [ ] research;
[ ] medical education.

EFFECT OF COPY: A copy of this form has the same effect as the original.

I understand the purpose and effect of this document.

_____ _____
(date) (sign your name)

_____
(print your name)

_____
(address)

_____
(city) (state) (zip code)

STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del.C. §§ 2502, 2503, in our presence, who in his/her presence, at his/her

request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

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A. The Declarant is mentally competent.

B. That neither of us is prohibited by §2503 of Title 16 of the Delaware Code from being a witness. Neither of us:

1. Is related to the declarant by blood, marriage or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; or
6. Is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____ _____, is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Witness	Witness
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city, state, zip code)	(city, state, zip code)
_____	_____
(signature of witness) (date)	(signature of witness) (date)

(Optional)

Sworn and subscribed to me this _____ day of _____.

My term expires: _____ _____
(Notary)

Rhode Island Durable Power Of Attorney For Health Care

AN ADVANCE CARE DIRECTIVE

"A GIFT OF PREPAREDNESS"

INTRODUCTION

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YOUR RIGHTS

Adults have the fundamental right to control the decisions relating to their health care. You have the right to make medical and other health care decisions for yourself so long as you can give informed consent for those decisions. No treatment may be given to you over your objection at the time of treatment. You may decide whether you want life sustaining procedures withheld or withdrawn in instances of a terminal condition.

What is a Durable Power of Attorney for Health Care?

This Durable Power of Attorney for Health Care lets you appoint someone to make health care decisions for you when you cannot actively participate in health care decision making. The person you appoint to make health care decisions for you when you cannot actively participate in health care decision making is called your agent. The agent must act consistent with your desires as stated in this document or otherwise known. Your agent must act in your best interest. Your agent stands in your place and can make any health care decision that you have the right to make.

You should read this Durable Power of Attorney for Health Care carefully. Follow the witnessing section as required. To have your wishes honored, this Durable Power of Attorney for Health Care must be valid.

REMEMBER

- You must be at least eighteen (18) years old.
- You must be a Rhode Island resident.
- You should follow the instructions on this Durable Power of Attorney for Health Care.
- You must voluntarily sign this Durable Power of Attorney for Health Care.
- You must have this Durable Power of Attorney for Health Care witnessed properly.
- No special form must be used but if you use this form it will be recognized by health care providers.
- Make copies of your Durable Power of Attorney for Health Care for your agent, alternative agent, physicians, hospital, and family.
- Do not put your Durable Power of Attorney for Health Care in a safe deposit box**.**
- Although you are not required to update your Durable Power of Attorney for Health Care, you may want to review it periodically.

Commonly Used Life-Support Measures Are Listed on the Back Inside Page

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(RHODE ISLAND HEALTH CARE ADVANCE DIRECTIVE)

I, _____,
(Insert your name and address)
am at least eighteen (18) years old, a resident of the State of Rhode Island, and understand this document allows me to name another person (called the health care agent) to make health care decisions for me if I can no longer make decisions for myself and I cannot inform my health care providers and agent about my wishes for medical treatment.

PART I: APPOINTMENT OF HEALTH CARE AGENT
THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
FOR ME IF I CAN NO LONGER MAKE DECISIONS

Note: You may not appoint the following individuals as an agent:

(1) your treating health care provider, such as a doctor, nurse, hospital, or nursing home,
(2) a nonrelative employee of your treating health care provider,
(3) an operator of a community care facility, or
(4) a nonrelative employee of an operator of a community care facility.

When I am no longer able to make decisions for myself, I name and appoint _____ to make health care decisions for me. This person is called my health care agent.

Telephone number of my health care agent: _____
Address of my health care agent: _____
_____

You should discuss this health care directive with your agent and give your agent a copy.

(OPTIONAL)
APPOINTMENT OF ALTERNATE HEALTH CARE AGENTS:

You are not required to name alternative health care agents. An alternative health care agent will be able to make the same health care decisions as the health care agent named above, if the health care agent is unable or ineligible to make health care decisions for you. For example, if you name your spouse as your health care agent and your marriage is dissolved, then your former spouse is ineligible to be your health care agent.

When I am no longer able to make decisions for myself and my health care agent is not available, not able, loses the mental capacity to make health care decisions for me, becomes ineligible to act as my agent, is not willing to make health care decisions for me, or I revoke the person appointed as my agent to make health care decisions for me, I name and appoint the following persons as my agent to make health care decision for me as authorized by this document, in the order listed below:

_____ **My Initials**

My **First Alternative Health Care Agent**: _____
Telephone number of my first alternative health care agent: _____
Address of my first alternative health care agent: _____
_____

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My **Second Alternative Health Care Agent**: _____
Telephone number of my second alternative health care agent: _____
Address of my second alternative health care agent: _____
_____

My health care agent is automatically given the powers I would have to make health care decisions for me if I were able to make such decisions. Some typical powers for a health care agent are listed below in (A) through (H). My health care agent must convey my wishes for medical treatment contained in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest. A court can take away the power of an agent to make health care decisions for you if your agent:

(1) Authorizes anything illegal,
(2) Acts contrary to your known wishes, or
(3) Where your desires are not known, does anything that is clearly contrary to your best interest.

Whenever I can no longer make decisions about my medical treatment, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatments, services, tests, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about mental health treatment.
(B) Advocate for pain management for me.
(C) Choose my health care providers, including hospitals, physicians, and hospice.
(D) Choose where I live and receive health care which may include residential care, assisted living, a nursing home, a hospice, and a hospital.
(E) Review my medical records and disclose my health care information, as needed.
(F) Sign releases or other documents concerning my medical treatment.
(G) Sign waivers or releases from liability for hospitals or physicians.
(H) Make decisions concerning participation in research.

If I DO NOT want my health care agent to have a power listed above in (A) through (H) OR if I want to LIMIT an power in (A) through (H), I must say that here:

_____
_____
_____
_____

_____ **My Initials**

PART II: HEALTH CARE INSTRUCTIONS

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition in certain circumstances or to prolong my life in other circumstances. Many medical treatments can be started and then stopped if they do not help. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start the heart, surgeries, dialysis, antibiotics, and blood transfusions. The back inside page has more information about life-support measures.

OPTIONAL -FOR DISCUSSION PURPOSES

A discussion of these questions with your health care agent may help him or her make health care decisions for you which reflect your values when you cannot make those decisions.

These are my views which may help my agent make health care decisions:

1. Do you think your life should be preserved for as long as possible? Why or why not?

_____
_____
_____

2. Would you want your pain managed, even if it makes you less alert or shortens your life?

_____
_____
_____

3. Do your religious beliefs affect the way you feel about death? Would you prefer to be buried or cremated?

_____
_____
_____

4. Should financial considerations be important when making a decision about medical care?

_____
_____
_____

5. Have you talked with your agent, alternative agent, family and friends about these issues?

_____
_____
_____

_____ My Initials

Here are my desires about my health care to guide my agent and health care providers.

4

1. If I am close to death and life support would only prolong my dying:

INITIAL ONLY ONE:
_____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____ I want all life support that may apply.
_____ I want NO life support.

2. If I am unconscious and it is very unlikely that I will ever become conscious again:

INITIAL ONLY ONE:
_____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____ I want all other life support that may apply.
_____ I want NO life support.

3. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

INITIAL ONLY ONE:
_____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____ I want all life support that may apply.
_____ I want NO life support.

Additional statement of desires, special provisions, and limitations regarding health care decisions *(More space is available on page 8)*:

_____

_____

ORGAN DONATION

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **transplant**. *(Initial if applicable)*

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **research**. *(Initial if applicable)*

_____ My Initials

RELIGIOUS AND SPIRITUAL REQUESTS

Do you want your Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor contacted if you become sick?

INITIAL ONLY ONE:
_____ Yes _____ No

Name of Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor:
_____

Address:_____

Phone Number: _____

DURATION

Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.

I do not want this durable power of attorney for health care to exist until revoked. I want this durable power of attorney for health care to expire on _____
(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

REVOCATION

I can revoke this Durable Power of Attorney for Health Care at any time and for any reason either in writing or orally. If I change my agent or alternative agents or make any other changes, I need to complete a new Durable Power of Attorney for Health Care with those changes.

PART III: MAKING THE DOCUMENT LEGAL

I revoke any prior designations, advance directives, or durable power of attorney for health care.

Date and Signature of Principal

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____
Signature Date signed:

_____ My Initials

DATE AND SIGNATURES OF TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC

4

Two qualified witnesses or one notary public must sign the durable power of attorney for health care form at the same time the principal signs the document. The witnesses must be adults and must not be any of the following:

(1) a person you designate as your agent or alternate agent,
(2) a health care provider,
(3) an employee of a health care provider,
(4) the operator of a community care facility, or
(5) an employee of an operator of a community care facility.

I declare under the penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, or an employee of an operator of a community care facility.

OPTION ONE:

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

----------OR----------

OPTION TWO:

Signature of Notary Public: _____
Print Name: _____
Commission Expires: _____
Business Address: _____
Date: _____

_____ **My Initials**

TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC DECLARATION

At least one of the qualified witnesses or the notary public must make this additional declaration:

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Signature: _____

Print Name: _____

PART IV: DISTRIBUTING THE DOCUMENT

You are not required to give anyone your Durable Power of Attorney for Health Care, but if it cannot be found at the time you need it, it cannot help you. For example, you are unable to participate in making health care decisions and your Durable Power of Attorney for Health Care is a safe deposit box, the agent, physician and other health care providers will not have access to it and they will not be able to respect your medical treatment wishes. You may want to give a copy of your Durable Power of Attorney for Health Care to some or all of the persons listed below so that it can be available when you need it.

(Name) (Address) (Phone)

❑ Health Care Agent

_____

❑ First Alternative Health Care Agent

_____

❑ Second Alternative Health Care Agent

_____

❑ Physician

_____

❑ Family

_____

❑ Lawyer

_____

❑ Others

_____

_____ My Initials

ADDITIONAL SPACE FOR INFORMATION

4

_____ My Initials

COMMONLY USED LIFE-SUPPORT MEASURES

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

When used quickly in response to a sudden event like a heart attack or drowning, CPR can be life-saving. But the success rate is extremely low for people who are at the end of a terminal disease process. Critically ill patients who receive CPR have a small chance of recovering or leaving the hospital.

Rhode Islanders with a terminal condition who do not want rescue/ambulance service/emergency medical services personnel to perform CPR may join COMFORT ONE. Rescue/ambulance/emergency workers will provide comfort measures but will not perform CPR or any resuscitation. To join COMFORT ONE, speak to your physician. ONLY your physician can enroll you in the COMFORT ONE PROGRAM. Your physician writes a medical order directing rescue/ambulances service/emergency personnel not to start CPR which is filed with the Rhode Island Department of Health.

Mechanical Ventilation

Mechanical ventilation is used to help or replace how the lungs work. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure happens due to injuries to the upper spinal cord or a progressive neurological disease.

Some people on long-term mechanical ventilation are able to enjoy themselves and live a quality of life that is important to them. For the dying patient, however, mechanical ventilation often merely prolongs the dying process until some other body system fails. It may supply oxygen, but it cannot improve the underlying condition.

When discussing end-of-life wishes, make clear to loved ones and your physician whether you would want mechanical ventilation if you would never regain the ability to breathe on your own or return to a quality of life acceptable to you.

Artificial Nutrition and Hydration

Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluid through a tube placed directly into the stomach, the upper intestine, or a vein. Artificial nutrition and hydration can save lives when used until the body heals.

Long-term artificial nutrition and hydration may be given to people with serious intestinal disorders that impair their ability to digest food, thereby helping them to enjoy a quality of life that is important to them. Sometimes long-term use of tube feeding frequently is given to people with irreversible and end-stage conditions which will not reverse the course of the disease itself or improve the quality of life. Some health care facilities and physicians may not agree with stopping or withdrawing tube feeding. You may want to talk with your loved ones and physician about your wishes for artificial nutrition and hydration in your Durable Power of Attorney for Health Care.

INSTRUCTIONS
To Living Will

A living will is a written document which directs your physician to withhold or stop life-sustaining medical procedures if you develop a terminal condition and can't state your wishes at the time a decision about those kinds of procedures must be made.

Rhode Island law suggests a form of living will but does not require its exclusive use. If you decide to sign a living will, you may use the form supplied with these instructions or make your own living will form. If you use this form, please read and follow these instructions carefully.

1. Print your name in the first line of the form.

2. Place a check mark in the third paragraph to indicate whether you want artificially-administered nutrition and hydration (food and water) to be stopped or withheld like any other life-sustaining treatment. Remember, if you do not want artificial nutrition and hydration, your living will must say so.

3. Complete the day, month and year that you sign at the bottom of this form.

4. Sign your name on the signature line (or if you are unable to do so, have someone do it for you) before two (2) witnesses who know you and are at least 18 years old.

5. Print your address on the address line.

6. Have the two (2) witnesses sign their names and print their addresses where indicated below your signature. The witnesses may not be related to you by blood or marriage.

7. Give a signed copy of your living will to your physician for your medical records.

   Remember, you may revoke your living will at any time simply by telling your physician not to follow it.

NOTE: This information is provided to make you generally aware of Rhode Island law about living wills and is not intended as legal advice for your particular situation. For legal advice about living wills or your health care rights, you should consult with an attorney.

STATE OF RHODE ISLAND

4

CHAPTER 23-4.11
A declaration may, but need not, be in the following form:

RIGHTS OF THE TERMINALLY ILL ACT

DECLARATION

I, _____, being of sound mind willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, so hereby declare:

If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization ☐ includes ☐ does not include

the withholding or withdrawal of artificial feeding. *(check only one box above)*

Signed this _____ day of _____, _____.

_____
Signature of Declarant

_____
Address

The Declarant is personally known to me and voluntarily signed this document in my presence. I am not related to the Declarant by blood or marriage.

_____ _____
Witness Witness

_____ _____
Address Address

Future medical treatment: advance statements and advance directives or living wills

Advance statements and advance directives or living wills allow people to state what forms of treatment they would or would not like carried out should they become unable to decide for themselves in the future. The Alzheimer's Society supports the use of advance directives because they enable those with dementia to have a say in their future care.

We would like your views on this draft sheet and attached form. Please contact Tarun Pamneja in the Society's public affairs team on 020 7306 0839 or email tpamneja@alzheimers.org.uk.

Most people prefer not to think about illness and death. However, many of us are concerned about how decisions about medical treatment might be taken should we lose the ability (the 'capacity' or 'competence') to decide for ourselves.

People with Alzheimer's disease and other forms of dementia, and those who may develop dementia in the future, are often anxious about what will happen should they reach a stage where they are unable to decide or explain how they would like to be treated. They may fear that life-sustaining or life-prolonging treatments will continue to be provided long after they are able to achieve a level of recovery or length or quality of life that they would at present consider to be acceptable or tolerable.

Definitions

The terms 'advance statement' and 'advance directive' or 'living will' are often used interchangeably. However, they have different meanings.

Advance statement is the general term for an act whereby a person, while mentally competent, specifically makes arrangements about their future health care should they become unable to do this in the future. This may be achieved either through a document which has become known as an **advance directive** or **living will** (which is legally binding in the UK) or by nominating someone to be consulted about treatment decisions (the **health care proxy** or **welfare attorney**) or by a combination of both. Health care proxies or welfare attorneys do not have current legal status in England, Wales or Northern Ireland. It is nevertheless good practice to involve them in your living will.

An **advance statement** is a statement of views or wishes to be taken into account in decision-making and is not intended to be binding on the health care team. An **advance directive** is intended to be a binding refusal of treatment.

Capacity or **competence** is defined as the ability to understand the implications of a decision. A person is deemed to have capacity or competence if he or she:

- can understand and retain the information relevant to the decision in question
- believes it and can reflect on that information to arrive at a choice
- can then express that choice.

A diagnosis of dementia does not necessarily mean a lack of capacity.

For people with dementia the loss of their ability to cope may be a gradual process, so the point at which they are no longer able to make a decision is difficult to pinpoint. Also, people may be quite capable of making their own decisions at times but at other times their dementia can significantly affect their capacity and abilities.

In cases of fluctuating or temporary incapacity an assessment must be made of the person's capacity to make a particular decision at the time the decision has to be made.

Issuing or writing advance statements

Your advance statement may be:

- **A requesting statement reflecting your individual aspirations and preferences**
  This can help health care professionals identify how you would like to be treated without binding them to that course of action if it conflicts with their professional judgment.

- **A statement of your general beliefs and aspects of life which you value**
  This makes no specific request or refusal but attempts to give a biographical picture to aid others in deciding what you would want – your personal 'values history'.
- **A statement nominating someone whom you would like to be consulted at the time a decision has to be made**
  The views expressed by them should reflect what you would want, so you must ensure that you have told this person what you would find acceptable or unacceptable.
- **A clear instruction refusing some or all medical procedures (an advance directive or living will)**
- **A statement which does not refuse particular treatments but specifies a degree of irreversible deterioration after which no life-sustaining or life-prolonging treatment should be given**
- **A combination of the above.**

Formulating an advance statement may or may not be a complex process. It is up to the individual to decide how detailed they wish their statement to be. However, because an advance statement concerns health care, the Society recommends that you discuss it with your doctor before drafting it.

A further advantage of such a discussion is that, should health care professionals later question your mental competence at the time you wrote the statement, they will be able to check this with your doctor and your views and wishes will be taken seriously.

When drafting an advance statement, you may choose to use your own form of words covering all or some of the above options. Alternatively, you may prefer to use a standard form for an advance directive such as the one attached, adding your own special wishes and 'values history' and/or nominating a health proxy.

It is important to include a statement about when you want your advance statement to come into effect. You may specify, for example, that it will come into effect only in the case of terminal illness, or in a situation where you are unable to make decisions for yourself and where you would view continuing treatment as unduly burdensome even though you are not terminally ill. You may wish to include a statement about specific treatments such as cardiopulmonary resuscitation or artificial feeding and hydration. You should also include a note that your advance statement was made without duress.

What are the advantages and disadvantages of deciding in advance?

When a health care team is faced with a difficult decision about what treatment or care to give, your advance statement will provide the best possible guide and will help to ensure that your wishes are taken into account.

Preparing an advance statement can lead to dialogue with doctors and nurses that might otherwise be delayed until it is too late.

The statement also provides you with the opportunity to discuss difficult issues with family and close friends, relieving them of some of the burden of decision-making at what can be a stressful time.

It is important to review and, if you so wish, revise your statement periodically.

Are advance statements legally enforceable?

In England, Wales and Northern Ireland there is no act of parliament related to the subject. However, an advance directive (refusal of treatment) is likely to be legally binding provided the following conditions are met:

- It is clear.
- You wrote it when you were mentally competent and fully informed about the consequences of refusal of treatment, including the fact that it might hasten your death.
- You intended the refusal to apply in the situation which has arisen.
- The decision was your own and not made under the influence of others.

It is unlikely that legal recognition would be given to a statement specifying a degree of irreversible deterioration after which no treatment aimed only at sustaining life should be given.

In England, Wales and Northern Ireland no one has the legal right to decide for a person without capacity. No one can give consent to medical treatment on behalf of another person. Your health care proxy should be involved in discussions about treatment, and the health care team should take information provided by them into account.

However, such information is not legally binding and the ultimate decisions about your care remain with the team.

The Adults with Incapacity (Scotland) Bill allows for a proxy decision-maker (a welfare attorney) legally to refuse treatment on behalf of an incapacitated person over the age of 16 years.

What an advance statement cannot do

You cannot use an advance statement to:

- refuse basic nursing care essential to keep you comfortable, such as washing, bathing and mouth care
- refuse the offer of food or drink by mouth
- refuse the use of measures solely designed to maintain your comfort – for example, painkillers
- demand care that the health care team considers inappropriate for you
- ask for anything which is against the law such as euthanasia and help in committing suicide.

The British Medical Association supports the principle of advance statements and recognises that health care professionals may be legally liable if they disregard the terms of an advance directive.

Practicalities

You can either use the advance directive form attached or use your own wording. Alternatively you can use the form as a basis and add your own wording where the form does not cover all you wish to say.

If you choose to draft your own advance statement and/or advance directive, the minimum information you need to include is:

- full name
- address
- name, address and telephone number of GP
- whether advice was sought from a health care professional
- date
- signature
- dated signature of at least one witness over the age of 18 years who should not be a partner, spouse, relative or anyone else who stands to benefit under your ordinary will. The witness should not be your health care proxy
- a clear statement of your wishes and values
- if applicable, the name, address and telephone number of the person you have nominated to be consulted about treatment decisions and, preferably, a dated signature that they have agreed to do so and have discussed your wishes with you
- where relevant, the date that you reviewed and, if necessary, revised your advance statement with your signature.

We recommend that you review and, if you so wish, revise your statement regularly, perhaps every six months.

You do not need to use a solicitor to draw up an advance statement, but where you are uncertain, a lawyer can help to ensure that your views are clearly expressed.

We strongly recommend that you do not draw up any advance statement without discussion with your doctor. He or she will be able to discuss the likely course of your illness and help you understand the advantages and disadvantages of choosing or refusing medical procedures in advance. They will also advise on some of the problems that may arise from an unclear statement. And they will be able to confirm that you were mentally competent at the time that you issued your advance statement.

You will need at least four or five copies of your statement: one for your GP to keep in your records; one for your hospital team to place in your case notes; one for a close relative or friend; one for yourself; and one for your proxy if applicable.

The most frequently asked questions about living wills

1 Is my living will legally enforceable?

Yes. Although there is no law that governs the use of living wills, under common law they are legally enforceable as long as they are drawn up whilst the patient is fully able, they apply to the patient's circumstances and have not since been changed.

2 How long is my living will valid for, and do I have to renew it?

Your living will is valid from the date you sign it, and stays valid until you change it. However, to show that it truly states your current wishes, we recommend that you update it every few years – the British Medical Association recommend every five years. You can do this by signing and dating the forms in the space provided.

3 Do I have to give a living will form to my solicitor?

No. A living will only deals with your medical treatment. It is entirely separate from documents such as your will.

4 Does my doctor have to sign my living will form?

No, this isn't necessary. However, we recommend that your doctor signs the form to show that he or she fully understands your wishes about treatment. Most important, make sure that a copy of your living will is placed in your medical records, and ensure that the relevant people know that it is there.

5 Can my family overturn my living will?

No. A living will is a statement of your wishes and cannot be contested by anyone else so long as it is valid – that is, it applies in the circumstances, you fully understood what you were requesting, and you have not subsequently changed it. This is why the form should be witnessed. If necessary, these witnesses could give evidence that you were mentally able when you signed the form.

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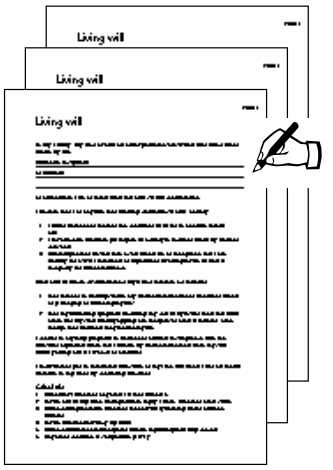

How to create your living will

1 Read through the living will form which follows carefully. Make sure you understand and agree with what it says.

2 You will need two or three copies of the form:
– one for you to keep
– one for your GP to keep with your medical records
– (if you wish) one for someone who you would like to be consulted about your treatment should this ever be necessary. This should be someone who knows and understands your wishes well, such as a family member or friend.

Make sure that you fully discuss what you want with these people.

Photocopies of a blank form will do, but they must each be filled in and witnessed as below.

3 Fill in your full name and address at the top of page 1.

4 If you have any further wishes relating to your treatment, you should write these down under **Notes** and continue on a separate sheet of paper if necessary. Attach a copy of any extra sheets to each living will form and tick the box at the bottom of page 2 that says you have done this.

5 On page 2 put the name and address of the person you would like to be consulted about your treatment. Simply cross it out if you do not want to name someone.

6 Next, fill in the name and address of your GP.
If you have talked it over with your GP (and we recommend that you do) tick the box.

7 You then need to fill in the other copies of the living will form in the same way.

8 All copies of the forms should then be signed by two people.
These people should not be close relatives and they should not expect to benefit from your will. If one of the signatories is your doctor this would be an advantage, but it is not necessary.

9 Sign and date all copies of the form in front of your witnesses.

10 Give one completed form to your GP to put into your medical records.
Give the second copy to the person you chose to speak for you (if there is one).
Finally, keep your own copy in a safe place.

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Living will

4

To my family, my doctor and all other persons concerned this directive is made by me

(full name in capitals)

of (address)

at a time when I am of sound mind and after careful consideration.

I declare that if at any time the following circumstances exist, namely:

1 I suffer from one or more of the conditions listed in the schedule below; and
2 I have become unable to participate effectively in decisions about my medical care; and
3 two independent doctors (one a consultant) are of the opinion that I am unlikely to recover from illness or impairment,

then and in those circumstances my directions are as follows:

1 that I am not to be subjected to any medical intervention or treatment aimed at prolonging or sustaining my life;

2 that any distressing symptoms (including any caused by lack of food and fluid) are to be fully controlled by appropriate analgesic or other treatment, even though that treatment may shorten my life.

Notes

Please insert any additional personal requests here. Continue on a separate sheet if necessary.

I consent to anything proposed to be done or omitted in compliance with the directions expressed above and I absolve my medical attendants from any civil liability arising out of such acts or omissions.

I reserve the right to revoke this **directive** at any time, but unless I do so it should be taken to represent my continuing directions.

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Schedule

1 Alzheimer's disease or any other form of dementia.
2 Severe and lasting brain damage due to injury, stroke, disease or other cause.
3 Advanced degenerative disease of the nervous system (eg motor neurone disease).
4 Severe immune deficiency (eg Aids).
5 Advanced disseminated malignant disease (eg widespread lung cancer).
6 Any other condition of comparable gravity.

I nominate* (name in capitals) _____

** Delete if not applicable*

of (address) _____

_____

telephone _____

as a person to be consulted by my medical attendants when considering what my intentions would be in any uncertain situation.

My general practitioner is:

(name of GP) _____

of (address) _____

_____

telephone _____

Before signing this directive I talked it over with my GP ☐
I have attached a sheet with further wishes about my treatment ☐

Tick boxes as appropriate

Signed _____ Date _____

Witnesses

4

We testify that the maker of this Directive signed it in our presence, and made it clear to us that he/she understood what it meant. We do not know of any pressure being brought on him/her to make such a directive and we believe it was made by his/her own wish. So far as we are aware we do not stand to gain from his/her death.

Witnessed by:

Signature	Signature
Name	Name
Address	Address

Reviews

This directive was reviewed and confirmed by me on the following dates:
(sign your name each time you enter a date)

Date	Signed
Date	Signed
Date	Signed