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EC93-447 Documents for Decision Making: Living Wills and Medical Durable Powers of Attorney

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Documents for Decision Making:

Living Wills and Medical Durable Powers of Attorney

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SECTION I

INTRODUCTION

Understanding Your Wishes

very person has a unique belief system including personal values based on family traditions, life experience, spiritual and religious beliefs, and knowledge. Medical decisions that we make for ourselves are based on those beliefs and values that matter most to us.

What in life gives us pleasure? What gives us sorrow? How do we feel about independence and control of our own life? About pain, illness, dying and death?

Most of us are aware of the court battles that have raged over "right to die" cases. The United States Supreme Court has recognized the right of a competent person to refuse medical treatment, including nutrition and hydration. The Court has also indicated that written statements, such as living will and medical durable powers of attorney, are evidence of the person's intent.

VOCABULARY TERMS

- **Living Will-** Nebraska LB 671, the Rights of the Terminally Ill Act, states that adults 19 years of age or older have the fundamental right to control decisions related to their own medical care by providing written instructions to their physician about the use of life-sustaining measures if their condition is terminal or in a persistent vegetative state.
- **Declarant**-individual who writes a living will or medical durable power of attorney to declare their wishes if they become incapacitated.
- **Medical Durable Power of Attorney**- Nebraska LB 696 allows Nebraskans to appoint a third party to make medical decisions for them when they are incapable of doing so themselves.
- **Principle**- adult who, when competent, confers upon another adult a power of attorney for health care.
- **Attorney-in-fact**- adult who has been designated to have durable power of attorney for health care on behalf of the principle in the event the principle is incapable.
- **Successor attorney-in-fact**- adult who is designated to serve in place of the original attorney-in-fact when the original attorney-in-fact is not reasonably available.
- **Medical Directive**- a more detailed form of living will which states the individual's wishes regarding various types of medical treatment in several representative situations so that personal desires can be respected.

Understanding and Using Medical Advance Directives

Since December 1, 1991, the Patient Self-Determination Act which was passed by Congress has required that health care facilities (such as hospitals and nursing homes) receiving federal funds such as Medicare and Medicaid inform patients of their rights under their states' law to formulate medical advance directives such as the ones that will be discussed in this publication.

This publication is intended to increase knowledge of "living wills" and "medical durable powers of attorney" legislation passed by the Nebraska Legislature in February 1992. It will provide a discussion of the complex ethical, legal, medical, economic and policy issues that are involved and will provide the tools necessary to execute writing these legal documents.

Section II "Living Wills" provides a discussion of the Nebraska Rights of the Terminally Ill Act, which provides adults the right to provide written instructions to their physician about the use of life-sustaining measures if their condition is terminal. The section on "Medical Durable Powers of Attorney" allows Nebraskans to appoint a third party to make medical decisions for them when they are incapable of doing so themselves.

Section III provides the "Medical Directive" which should be used with living wills and medical durable powers of attorney to provide the substance for decision making. This document will help to spell out the details for

various types of medical treatment in several situations so that your wishes can be respected.

A discussion of the type of questions raised on the "Values History Form" in Section IV provides a basis for families, friends, attorney-in-fact, and physicians when these decisions need to be made. Family misunderstandings and disagreements can be minimized when wishes are documented before a medical crisis occurs. This task is appropriate not just for older people. Often some of the most difficult medical decisions must be made on behalf of younger patients.

Section V is a discussion of religious positions. Several faiths, denominations and religious groups have provided their resolutions and information on death, dying, personal dignity and decisions.

You may want to write out some of your thoughts before you talk with anyone else. Talking later with family and friends can help them feel reassured about your wishes.

LIVING WILLS

What is a Living Will?

In February, 1992, Nebraska's Legislature passed LB 671, the Rights of the Terminally Ill Act, which states that adults have the fundamental right to control decisions related to their own medical care. This law provides Nebraska adults the right to provide written instructions—commonly called a living will—to their physician about the use of life-sustaining measures if their condition is terminal.

A living will is not a "will" in the traditional sense of the term. A living will is the legal document that provides a way for you to state, in advance, whether or not you wish to have life-sustaining medical treatment withdrawn or withheld in the event of a persistent vegetative state or a terminal condition. It is a statement concerning your wishes about the use of medical technology to sustain life artificially when there is no possibility of recovery.

When Would A Living Will Go Into Effect?

In Nebraska, a living will requires these specific circumstances:

- **must be in writing,**
- **executed by an adult 19 years of age or older or who is or has been married,**
- **signed by declarant (or signed by someone else—other than one of the witnesses mentioned below—but only at declarant's expressed direction and in her/his presence),**
- **witnessed by two adults or a notary public. No more than one witness shall be an administrator or employee of a health care provider who is caring for you and no witness shall be an employee of a life or health insurance provider for you. The restrictions upon who may witness the signing shall not apply to a notary public.**

A physician or other health care provider who is furnished a copy of the declaration (living will) shall make it a part of the declarant's medical record. The declaration shall become operative when all of the following conditions are met:

- **when it is communicated to the attending physician,**
- **when the declarant is determined by the attending physician to be in a terminal condition or in a persistent vegetative state,**
- **when the declarant is determined by the attending physician to be unable to make decisions regarding administration of life-sustaining treatment, and**
- **when the attending physician has notified a reasonably available member of the declarant's immediate family or guardian of the diagnosis and the intent to invoke the patient's declaration.**

SECTION II

Can A Living Will Be Canceled?

A declarant may revoke a declaration at any time and in any manner without regard to the declarant's mental or physical condition. This revocation shall be effective upon its communication to the attending physician or other health care provider by the declarant or a witness to the revocation and be made a part of the medical record. When a revocation is written, it should be distributed to all involved.

Other Facts About The Statute

The Rights of the Terminally Ill Act shall not affect the responsibility of the attending physician or other health care provider to provide treatment, including nutrition and hydration, for a patient's comfort care, or alleviation of pain.

LIVING WILL DECLARATION

If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Signed this_____day of_____

Signature_____

Address_____

_____

Witness_____

Address_____

_____

The declarant voluntarily signed this writing in my presence.

_____

Notary Public

Life-sustaining treatment shall not be withheld or withdrawn from an individual known to the attending physician to be pregnant so long as it is probable that the fetus will develop to the point of live birth with continued application of life-sustaining treatment.

An attending physician or other health care provider who is unwilling to comply with the Rights of the Terminally Ill Act shall take all reasonable steps as promptly as practicable to transfer care of the declarant to another physician or health care provider who is willing to do so.

Death resulting from the withholding or withdrawal of life-sustaining treatment in accordance with the Rights of the Terminally Ill Act shall not constitute, for any purpose, a suicide or homicide. A policy of life insurance or annuity shall not be legally impaired or invalidated by the withholding or withdrawal of life-sustaining treatment from an insured.

In the absence of knowledge to the contrary, a physician or other health care provider may assume that a declaration complies with the Rights of the Terminally Ill Act and is valid. A declaration executed in another state in compliance with the law of that state or of Nebraska shall be valid. An instrument executed anywhere before July 15, 1992 (effective date of this act) which substantially complies with the Rights of the Terminally Ill Act (two witnesses or notary public) shall be effective.

Should I Have A Living Will?

Optimally, each person should make this decision after thinking about her or his values and beliefs about medical care. It is important to share your thoughts and actions with your family, friends, attorney-in-fact, physician, attorney and others who may potentially enter into a decisionmaking process for you. The goal is to make a careful decision whether or not to make a living will.

Statutory Form For Living Will

A declaration directing a physician to withhold or withdraw life-sustaining treatment may, but need not, be in the statutory form provided by the Nebraska Rights of the Terminally Ill Act. This form is printed to the left.

MEDICAL DURABLE POWERS OF ATTORNEY

Health Care Decisions

In February, 1992, Nebraska Legislators also passed LB 696 that would allow Nebraskans to appoint a third party to make medical decisions for them when they are incapable of doing so themselves. It would also provide a means to request that every life sustaining effort be made. This is known as a medical durable power of attorney. Prior to passage, Nebraska was one of only two states that did not have either a living will law or provision for durable power of attorney for health care decisions.

Unlike living wills, medical durable powers of attorney are not limited to instances where a person is terminally ill. They can address everyday health care decisions as well for an incompetent patient.

How Do I Create A Medical Durable Power of Attorney?

The intent of the law is to establish a decisionmaking process which allows a competent adult to designate another person to make health care and medical treatment decisions if the adult becomes incapable of making such decisions. The medical durable power of attorney:

- **must be in writing;**
- **must identify the principal (adult who, when competent, confers upon another adult a power of attorney for health care);**
- **will designate attorney-in-fact to have power of attorney for health care;**
- **may designate another competent adult as a successor attorney-in-fact to serve in place of the original attorney-in-fact when the original attorney-in-fact is not reasonably available;**
- **specifically authorize the attorney-in-fact to make health care decisions on behalf of the principal in the event the principal is incapable;**
- **show the date of its execution; and be witnessed and signed by at least two adults;**
- **may require a second opinion on the determination of the principal's incapacity to make health care decisions.**

The principal's spouse, parent, child, grandchild, sibling, presumptive heir, attending physician, employee of a life or health insurance provider for the principal, or attorney-in-fact cannot serve as a witness. No more than one witness may be an administrator or employee of a health care provider who is caring for or treating the principal. The attending physician, an employee of the attending physician, the owner or employee of a health care provider in or of which the principal is a patient or resident, and a person serving as an attorney-in-fact for ten or more principals is not allowed to serve as an attorney-in-fact.

How Does The Medical Durable Power of Attorney Become Effective?

The medical durable power of attorney shall be made a part of the principal's medical record with the attending physician. It will continue in effect until it is revoked, until the principal's death, or until a person is again capable of making their own health care decisions.

A determination that a principal is incapable of making health care decisions shall be made in writing by the attending physician and any consulting physician by documenting the cause and nature of the principal's incapacity. Notice of a determination shall be given by the attending physician to the principal when there is any indication of the principal's ability to comprehend the notice, to the attorney-in-fact, and to the health care provider. Upon notification, the attorney-in-fact shall notify the next of kin unless the principal has directed otherwise in the document.

If a dispute arises as to whether the principal is incapable, a petition may be filed with the county court in the county in which the principal resides requesting the court's determination as to whether the principal is incapable of making health care decisions. The court shall then appoint a guardian ad litem to represent the principal and conduct a hearing on the petition

within seven days. If the court determines that the principal is incapable, the authority, rights, and responsibilities of the principal's attorney-in-fact shall become effective.

The attorney-in-fact shall not have authority to make any decision when the principal is known to be pregnant that will result in the death of the principal's unborn child and it is probable that the unborn child will develop to the point of live birth with continued application of health care.

Can I Cancel A Medical Durable Power of Attorney If I Change My Mind?

The medical durable power of attorney may be revoked orally or in writing at any time by a principal who is competent. It is a good idea to periodically (about every five years) review your medical durable power of attorney to see if it still expresses your wishes. If so, it is recommended that you put your initials and the date by your original signature as a reconfirmation. When a revocation is written, it should be distributed to all involved.

WARNING TO PERSON EXECUTING A MEDICAL DURABLE POWER OF ATTORNEY:

This is an important legal document. It creates a durable power of attorney. Before signing this document you should know these important facts:

(a) This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you when you are determined to be incapable;

(b) The person you designate as your attorney-in-fact will not have the authority to consent to the withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition or hydration unless you give him or her that authority in this power of attorney for health care or in some other clear and convincing manner;

(c) The person you designate as your attorney-in-fact has a duty to act consistently with your desires as stated in this document or otherwise made known by you or, if your desires are unknown, to act in a manner consistent with your best interests. The person you designate in this document does, however, have the right to withdraw from this duty at any time;

(d) You may specify that any determination that you are incapable of making health care decisions must be confirmed by a second physician;

(e) This medical durable power of attorney should be reviewed periodically. It will continue in effect indefinitely unless you exercise your right to revoke it. You have the right to revoke this power of attorney at any time while you are competent by notifying the attorney-in-fact or your health care provider of the revocation orally or in writing;

(f) Despite any provisions in this power of attorney for health care, you have the right to make health care decisions for yourself as long as you are not incapable of making those decisions; and

(g) If there is anything in this medical durable power of attorney you do not understand, you should seek legal advice. This medical durable power of attorney will not be valid for making health care decisions unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

A medical durable power of attorney executed before January 1, 1993 shall be effective if it fully complies with the terms of this legislation. But, it is necessary to have a notarized statement for power of attorney executed before January 1, 1993. Be sure to review these old documents to determine if they are appropriate to your needs.

A medical durable power of attorney which is executed in another state and is valid under the laws of that state shall be valid according to its terms.

Who Should Receive Copies Of The Medical Durable Power Of Attorney?

Copies of your medical durable power of attorney should go to your attorney-in-fact, family members, your attorney, your physician, other regular health care providers, and trusted friends. You might want to note on the copies where the original document is located and keep a list of who has copies.

Should I Have A Medical Durable Power Of Attorney?

Only you can make that decision. A medical durable power of attorney can empower a person of your choosing to act on your behalf, should you be unable to do so. Because of the potential responsibility and power your attorney-in-fact could have over your life, you will want to choose that person carefully.

STATUTORY FORM FOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A durable power of attorney for health care executed on or after January 1, 1993, should be substantially in the following form provided by the legislation.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I appoint _____

whose address is _____

and whose telephone number is_____,

as my, attorney-in-fact for health. I appoint _____,
as my successor attorney-in-fact for health care. I authorize my attorney-in-fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

I direct that my attorney-in-fact comply with the following instructions or limitations. _____

_____

I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment:

(optional)_____

_____

I direct that my attorney-in-fact comply with the following instructions on artificially administered

nutrition and hydration: (optional)_____

_____

_____
(Signature of person making designation/date)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal assigned or acknowledged his or her signature in this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney-in-fact by this document.

Witnessed by

_____ _____
(Signature of Witness/Date) (Signature of Witness)

_____ _____
(Printed Name of Witness) (Printed Name of Witness)

SECTION III

The Medical Directive

The Medical Directive states how you would like your health care handled if incompetent. It details your wishes regarding various types of medical treatment in several representative situations so that your desires can be respected. This Medical Directive form is copyrighted, 1990, by Linda L. Emanuel and Ezekiel J. Emanuel. The authors of this form advise that it should be completed following a discussion between the principal and his or her physician, so that the principal can be adequately informed of any pertinent medical information, and so that the physician can be appraised of the intentions of the principal and the existence of such a document which must be made part of the principal's medical records.** Since such wishes usually reflect personal, philosophical, and religious views, you may want to discuss the issues with your family, your friends, attorney-in-fact, or your religious leader before completing the form.

The form does not reflect the official policy of the American Medical Association. The format presented in this bulletin has been changed to reflect requirements of Nebraska state law.

** This form was originally published as part of an article by Linda L. Emanuel and Ezekiel J. Emanuel, "The Medical Directive: A New Comprehensive Advance Care Document," in *Journal of the American Medical Association* June 9, 1989; 261-3290.

Completing The Form

First you will be asked to consider six different situations that involve mental incompetence.

Each situation which follows describes varying levels of mental incompetence. With each situation you will need to initial each of the boxes with which you agree, that is with each form of treatment you wish to pursue.

For each of these situations, you will be asked to indicate your wishes concerning possible medical interventions ranging from pain medications to resuscitation. You can refuse a certain treatment or request that it definitely be used, should it be medically appropriate. Alternatively, you can state that you are unsure about your preference for the treatment, or that you would like it tried for a while but discontinued if it does not result in definite improvement.

This phase of completing the Medical Directive is best done in discussion with your physician.

Before recording a personal statement in the Medical Directive, you may find it helpful to consider the following question. What kind of medical condition, if any, would make life hard enough that you would find attempts to prolong it undesirable?

— None?
— Intractable pain?
— Permanent dependence on others?
— Irreversible mental damage?
— Another condition you would regard as intolerable? Under circumstances such as these, medical intervention may include only securing comfort; it may involve using ordinary treatments while avoiding more invasive ones; or employing those that offer improved function; or trying anything appropriate to prolonging life—regardless of quality.

You should record here anything you feel is necessary to clarify your personal values concerning the limits of life and the goals of medical intervention.

What To Do With The Form

To make the Medical Directive effective you must sign and date in the presence of two adults or a notary public (see the Nebraska signing requirements as detailed in Section II - Living Wills). The Medical Directive can be appended to the Living Will Declaration.

You should give a copy of the completed document to a family member, attorney-in-fact, friend, as well as your personal physician, to ensure that it will be available if it is needed.

Your physician should have a copy of it placed in your medical records and should flag it so that anyone who might be involved in your care can be aware of its presence.

This Medical Directive expresses, and shall stand for, my wishes regarding medical treatments in the event that illness should make me unable to communicate them directly. I make this Directive, being 19 years or more of age, or who is or has been married, of sound mind, and appreciating the consequences of my decision. INITIAL EACH BOX TO DOCUMENT YOUR WISHES.

SITUATION A If I am in a coma or a persistent vegetative state, and, in the opinion of my physician, have no known hope of regaining awareness and higher mental functions no matter what is done, then my wishes—if medically reasonable—for this and any additional illness would be:	I want	I want treatment tried. If no clear improvement, stop	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying), or major surgery (for example, removing the gall bladder or part of the colon)		Not applicable		
2. Mechanical breathing (respiration by machine, through a tube in the throat), or dialysis (cleaning the blood by machine or by fluid passed through the belly)				
3. Blood transfusions or blood products		Not applicable		
4. Artificial nutrition and hydration (given through a tube in a vein or in the stomach)				
5. Simple diagnostic tests (for example, blood tests or x-rays), or antibiotics (drugs to fight infection)		Not applicable		
6. Pain medications, even if they dull consciousness and indirectly shorten my life		Not applicable		

THE GOAL OF MEDICAL CARE SHOULD BE
(check one)

_____prolong life; treat everything
_____choose quality of life over longevity
_____provide comfort care only
_____other (please specify):_____

_____

Name_____

Date_____

Witness_____

Witness_____

SECTION III

SITUATION B

If I am in a coma and, in the opinion of my physician, have a small but uncertain chance of regaining higher mental functions, a somewhat greater chance of surviving with permanent brain damage, and a much greater chance of not recovering at all, then my wishes — if medically reasonable — for this and any additional illness would be:

	I want	I want treatment tried. If no clear improvement, stop	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying), or major surgery (for example, removing the gall bladder or part of the colon)		Not applicable		
2. Mechanical breathing (respiration by machine, through a tube in the throat), or dialysis (cleaning the blood by machine or by fluid passed through the belly)				
3. Blood transfusions or blood products		Not applicable		
4. Artificial nutrition and hydration (given through a tube in a vein or in the stomach)				
5. Simple diagnostic tests (for example, blood tests or x-rays), or antibiotics (drugs to fight infection)		Not applicable		
6. Pain medications, even if they dull consciousness and indirectly shorten my life		Not applicable		

THE GOAL OF MEDICAL CARE SHOULD BE
(check one)

_____ prolong life; treat everything
_____ attempt to cure, but reevaluate often
_____ choose quality of life over longevity
_____ provide comfort care only
_____ other (please specify):_____

_____

Name_____

Date_____

Witness_____

Witness_____

SITUATION C

If I have brain damage or some brain disease that in the opinion of my physician cannot be reversed and that makes me unable to recognize people, to speak meaningfully to them, or to live independently, and I also have a terminal illness, then my wishes — if medically reasonable — for this and any additional illness would be:

	I want	I want treatment tried. If no clear improvement, stop	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying), or major surgery (for example, removing the gall bladder or part of the colon)		Not applicable		
2. Mechanical breathing (respiration by machine, through a tube in the throat), or dialysis (cleaning the blood by machine or by fluid passed through the belly)				
3. Blood transfusions or blood products		Not applicable		
4. Artificial nutrition and hydration (given through a tube in a vein or in the stomach)				
5. Simple diagnostic tests (for example, blood tests or x-rays), or antibiotics (drugs to fight infection)		Not applicable		
6. Pain medications, even if they dull consciousness and indirectly shorten my life		Not applicable		

THE GOAL OF MEDICAL CARE SHOULD BE
(check one)

_____ prolong life; treat everything
_____ attempt to cure, but reevaluate often
_____ choose quality of life over longevity
_____ provide comfort care only
_____ other (please specify):_____

_____

Name_____

Date_____

Witness_____

Witness_____

SECTION III

SITUATION D	I want	I want treatment tried. If no clear improvement, stop	I am undecided	I do not want
If I have brain damage or some brain disease that in the opinion of my physician cannot be reversed and that makes me unable to recognize people, to speak meaningfully to them, or to live independently, but I have no terminal illness, then my wishes — if medically reasonable — for this and any additional illness would be:				
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying), or major surgery (for example, removing the gall bladder or part of the colon)		Not applicable		
2. Mechanical breathing (respiration by machine, through a tube in the throat), or dialysis (cleaning the blood by machine or by fluid passed through the belly)				
3. Blood transfusions or blood products		Not applicable		
4. Artificial nutrition and hydration (given through a tube in a vein or in the stomach)				
5. Simple diagnostic tests (for example, blood tests or x-rays), or antibiotics (drugs to fight infection)		Not applicable		
6. Pain medications, even if they dull consciousness and indirectly shorten my life		Not applicable		

THE GOAL OF MEDICAL CARE SHOULD BE
(check one)

_____ prolong life; treat everything
_____ attempt to cure, but reevaluate often
_____ choose quality of life over longevity
_____ provide comfort care only
_____ other (please specify):_____

_____

Name_____

Date_____

Witness_____

Witness_____

SITUATION E

If, in the opinion of my physician, I have an incurable chronic illness that involves mental disability or physical suffering and ultimately causes death, and in addition I have an illness that is immediately life threatening but reversible, and I am temporarily unable to make decisions, then my wishes — if medically reasonable — would be:

	I want	I want treatment tried. If no clear improvement, stop	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying), or major surgery (for example, removing the gall bladder or part of the colon)		Not applicable		
2. Mechanical breathing (respiration by machine, through a tube in the throat), or dialysis (cleaning the blood by machine or by fluid passed through the belly)				
3. Blood transfusions or blood products		Not applicable		
4. Artificial nutrition and hydration (given through a tube in a vein or in the stomach)				
5. Simple diagnostic tests (for example, blood tests or x-rays), or antibiotics (drugs to fight infection)		Not applicable		
6. Pain medications, even if they dull consciousness and indirectly shorten my life		Not applicable		

THE GOAL OF MEDICAL CARE SHOULD BE
(check one)

_____ prolong life; treat everything
_____ attempt to cure, but reevaluate often
_____ choose quality of life over longevity
_____ provide comfort care only
_____ other (please specify):_____

_____

Name_____

Date_____

Witness_____

Witness_____

SECTION III

SITUATION F

If I am in my current state of health (describe briefly):

_____

_____

_____

and then have an illness that, in the opinion of my physician, is life threatening but reversible, and I am temporarily unable to make decisions, then my wishes — if medically reasonable — would be:

	I want	I want treatment tried. If no clear improvement, stop	I am undecided	I do not want
1. Cardiopulmonary resuscitation (chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying), or major surgery (for example, removing the gall bladder or part of the colon)		Not applicable		
2. Mechanical breathing (respiration by machine, through a tube in the throat), or dialysis (cleaning the blood by machine or by fluid passed through the belly)				
3. Blood transfusions or blood products		Not applicable		
4. Artificial nutrition and hydration (given through a tube in a vein or in the stomach)				
5. Simple diagnostic tests (for example, blood tests or x-rays), or antibiotics (drugs to fight infection)		Not applicable		
6. Pain medications, even if they dull consciousness and indirectly shorten my life		Not applicable		

THE GOAL OF MEDICAL CARE SHOULD BE
(check one)

_____ prolong life; treat everything
_____ attempt to cure, but reevaluate often
_____ choose quality of life over longevity
_____ provide comfort care only
_____ other (please specify):_____

_____

Name_____

Date_____

Witness_____

Witness_____

VALUES HISTORY FORM

Spend some time reflecting and writing answers for the following questions. After you have completed this form, you may wish to provide copies for your family, friends, attorney-in-fact, doctor, and attorney. If you have a Living Will or Medical Durable Power of Attorney, you may wish to attach a copy of this form to those documents.

A. Your Overall Attitude Toward Your Health

1. How would you describe your current health status? If you currently have any medical problems, how would you describe them?

2. If you have current medical problems, in what ways, if any, do they affect your ability to function?

3. How do you feel about your current health status?

B. Your Perception of the Role of Your Doctor and Other Caregivers

1. What role do you want your doctor to have in your medical decisions?

2. Do you want your doctor to make the final decision concerning any treatment you might need?

3. How do you relate to your caregivers, including nurses, therapists, chaplains, social workers, etc.?

C. Your Thoughts About Independence and Control

1. Describe how independence and self-sufficiency affect your quality of life?

2. If you were to experience decreased physical and mental abilities, how would that affect your attitude toward independence and self-sufficiency?

3. Do you wish to make any general comments about the value of independence and control in your life?

D. Your Personal Relationships

1. Do you expect that your friends, family and/or others will support your decisions regarding medical treatment you may need now or in the future?

2. Have you made any arrangements for your family or friends to make medical treatment decisions on your behalf? If so, who has agreed to make decisions for you and in what circumstances?

3. What, if any, unfinished business from the past are you concerned about (e.g., personal and family relationships, business and legal matters)?

E. Your Attitude Toward Illness, Dying, and Death

1. What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

2. Where would you prefer to die?

3. How do you feel about the use of life-sustaining measures in the face of terminal illness?

permanent coma?

irreversible chronic illness (e.g., Alzheimer's disease)?

4. Do you wish to make any general comments about your attitude toward illness, dying, and death?

5. Have you made any arrangements to have your organs donated at the time of death? What are the details of these commitments?

F. Your Religious Background and Beliefs

1. What is your religious background?

2. How do your religious beliefs affect your attitude toward serious or terminal illness?

3. Does your attitude toward death find support in your religion?

4. How does your faith community view the role of prayer or religious sacraments in an illness?

G. Your Living Environment

1. What has been your living situation over the last 10 years (e.g., lived alone, lived with others, etc.)?

2. How difficult is it for you to maintain the kind of environment for yourself that you find comfortable? Does any illness or medical problem you have now mean that will be harder in the future?

3. As things get harder, what other choices or changes can you make in your living environment?

H. Your Attitude Concerning Finances

1. How much do you worry about having enough money to provide for your care?

2. Would you prefer to spend less money on health care or is it your feeling to use money as needed for care?

3. Do you wish to make any general comments concerning your finances and the cost of health care?

I. Your Wishes Concerning Your Funeral

1. What are you wishes concerning your funeral and burial or cremation?

2. Have you made your funeral arrangements? If so, with whom?

3. Do you wish to make any general comments about how you would like your funeral and burial or cremation to be arranged or conducted?

Optional Questions

1. How would you like your obituary (announcement of your death) to read?

2. Write yourself a brief eulogy (a statement about yourself to be read at your funeral).

A range of religious positions have been assembled in the publication ***WE AGREE — Christians and Jews Support The Premise. . . Individuals Have a Right To Die With Dignity.*** The information was originally compiled and published by the Older Women's League - Lincoln Chapter in cooperation with Decisions and Dignity in Dying, a coalition of Nebraskans for medical directives legislation. The denominational statements may not necessarily reflect all denominations' views or policy statements regarding the death with dignity issue.

This information has been assembled for the public and elected officials to raise awareness that there is more than one religious perspective on death, dying, personal dignity and decisions.

A wide variety of faiths, denominations and religious groups within the Christian and Jewish tradition have reviewed, studied and adopted resolutions and information supporting the premise that individuals have a right to die with dignity.

WE AGREE represents excerpts from statements about death with dignity as expressed by these local and national religious organizations:

Agudath Israel of America (Orthodox Judaism)

American Lutheran Church

Lutheran Church in America

Christian Church (Disciples of Christ)

Lincoln Friends Meeting (Quakers)

National Council of Jewish Women

Presbyterian Church U.S.A.

Spiritual Assembly of the Baha'is of Lincoln, NE

Union of American Hebrew Congregations

Unitarian Universalists

United Church of Christ

United Methodist Church

■ AGUDATH ISRAEL OF AMERICA (Orthodox Judaism)

"Halachic Living Will"

Two standardized forms, developed under the direction and approval of prominent rabbinic authorities from across the Orthodox Jewish spectrum, are designed to help observant Jews ensure that when medical decisions and post-death decisions are made by others on their behalf, such decisions will be made in accordance with halacha. The Halachic Living Will consists of two separate forms: (1) a formal legal document to be kept among your other valuable papers; and (2) a wallet-size "Emergency Instructions" card to be carried on your person.

Evangelical Lutheran Church of America (ALC and LCA have recently merged.) Both of the following social statements have been incorporated into the ELCA.

■ AMERICAN LUTHERAN CHURCH, JULY 1977

Death and Dying

Sustaining Life

When death is judged to be certain and imminent, we affirm that grave injustice to the respect and memory of persons is rendered if extraordinary technology is applied. Our highest concern is for the total person rather than technological curiosity and mechanical performance. We are confronted with values of human and personal life in the face of every death.

Wherever life support systems can be used to improve the quality of personal and biological life, we heartily affirm their use.

Allowing Death

We affirm that in many instances heroic and extraordinary means used to prolong suffering of both the dying person and the loved ones is unkind. Wherever personality and personhood are permanently lost, artificial supportive measures often are seen as unfair to the dignity of the person and an extreme cost that is burdensome to the family. Families in these cases need not feel a burden of guilt for refusal to try unusual, heroic, and extraordinary life support. Where physicians have determined the irreversible phase of a terminal illness, we affirm that the person, young or old, has a right to a peaceful death. As life draws to an end, with no hope for health restoration, permitting death is often the most heroic, caring, and charitable rendering of stewardship.

We affirm that every situation, in the context of dying persons, deserves consideration and decision on its own merit. We affirm that life is to be respected. Respect for the patient requires acceptance by others of that person's desires for life and death. Wise counsel by physicians, the clergy, and members of the health care team should be made available to every family and person facing the crisis of death. Wherever possible, the dying person has a right to be informed of the nature of the illness and the likelihood of imminent death. One should be so informed in love.

We affirm that direct intervention to aid the irremediably deteriorating and hopelessly ill person to a swifter death is wrong... [T]here is a distinct moral difference between killing and allowing to die.

■ LUTHERAN CHURCH IN AMERICA

Adopted by Eleventh Biennial Convention, Louisville, KY, September 1982. Death and Dying.

Ethical Decision-Making

Careful and prayerful reflection in the immediacy of the situation is an essential ingredient in a responsible decision-making process.

...it is possible to identify interpretive principles that are useful in shaping our response. These include the following:

1. Life is a gift of God, to be received with thanksgiving.
2. The integrity of the life processes which God has created should be respected; both birth and death are part of these life processes.
3. Both living and dying should occur within a caring community.
4. A Christian perspective mandates respect for each person; such respect includes giving due recognition to each person's carefully considered preferences regarding treatment decisions.
5. Truthfulness and faithfulness in our relations with others are essential to the texture of human life.
6. Hope and meaning in life are possible even in times of suffering and adversity — a truth powerfully proclaimed in the resurrection faith of the church.

In some cases, the person's clearly stated preferences, made before he or she lost the capacity to participate, are on record; respect for that person requires that these preferences be given recognition. In other cases, no preferences are on record because the person never gave expression to his or her preferences while still able to do so, and is now too weakened to respond. If the situation involves a child under the age of majority, who is therefore legally incompetent, or a person who is mentally impaired and hence unable to participate fully in the decision-making process, a shared decision-making process is preferable.... Participants in decision-making may include family members, the physician and other health care professionals, the pastor, and others close to the person,...a hospital ethics committee, if one exists, can be an important resource. Appeal to the courts should be avoided unless so doing is the only way to protect individual rights or to resolve the controversy.

Withdrawing and Withholding Treatment

Among the most difficult decisions which confront family members and others in

death-and-dying situations are those that involve withdrawing or withholding medical treatment.

A particular responsibility of each individual is making treatment preferences known, after careful consideration, so as to facilitate the decision-making process and relieve the burden on others. Living wills...represent one way of doing this. Other areas of broader responsibility for patients and family members include considering the possibility of organ donation as a means of sharing life with others, authorizing an autopsy, and the donation of the body for scientific purposes. Advocate with federal, provincial/state and local governments legislation and administrative regulations that advance the best interests of persons with respect to dying and death.

Individuals [should] prayerfully examine the ethical questions related to death and dying and make treatment preferences known to family members and to others as appropriate (e.g., by completing a living will).

■ CHRISTIAN CHURCH

(Disciples of Christ) *General Assembly, Kansas City, MO, October 1977*

Resolution Concerning Death With Dignity

WHEREAS, modern biological technology has developed powerful means of intervening in and delaying the dying process, and

WHEREAS, increasing numbers of adult Americans are dying of chronic disease, prolonged over a period of months or years, and

WHEREAS, increasing numbers of dying persons are hospitalized or receive care in other institutions (73% of the adults who died in 1965 received institutional care during the last year of their life and this percentage has grown steadily over the years from 37% in 1937), and

WHEREAS, increasing numbers of persons institutionalized in the terminal stage of illness have their life prolonged through artificial means, even in the face of extreme suffering, irretrievable loss of consciousness, and

WHEREAS, the intervention in the dying process through artificial means obscures the meaning of death, so that today it is more a matter of moral judgment than biological fact, and

WHEREAS, this situation has given rise to a number of ethical dilemmas, including the following:

1. patients frequently lose control over decisions affecting their death.
2. patient's dignity and quality of life may be sacrificed to the goal of cellular continuation.
3. grave financial burdens may accrue to families and to society in no hope of recovery, rehabilitation, or mentation.
4. disagreement and confusion often persist with regard to the issue of who the decision maker(s) should be in determining the nature of the treatment, or the cessation of treatment for a dying person.
5. increasing legal issues have arisen which may threaten the protection of the physician, the right of survivors to collect insurance payments, the availability of organs for transplantation, and the right of the patient to refuse treatment.

THEREFORE BE IT RESOLVED, that the General Assembly of the Christian Church (Disciples of Christ) meeting in Kansas City, MO, October 21-26. 1977:

1. encourage its congregations to study the issues related to dying with dignity.
2. request the General Minister and President to appoint a person or persons to develop a theological statement to help our members reflect on the theological issues which surround the dying person in this time.
3. encourage its members to engage in the dialogue pertaining to the formation of public policy toward the end that legislation which may develop in the various states is enriched by our concern for the moral issues at stake.

■ LINCOLN FRIENDS MEETING

(Quakers)

November 1991

We of the Lincoln Friends Meeting (Iowa Yearly Meeting of the Society of Friends,

Conservative) of Lincoln, Nebraska, support legislation to legalize Living Will Declarations in the state of Nebraska, so that family members, doctors, other medical personnel, institutions, and all others concerned with an individual's care will be legally and morally bound to act in accord with that individual's expressed directives about acceptable and unacceptable medical treatment and care.

■ NATIONAL COUNCIL OF JEWISH WOMEN

Adopted 38th National Convention, March 1990

The National Council of Jewish Women supports laws which protect the individual's right to choose to die with dignity as stated in our National Resolutions, 1990-1993.

We Therefore Endorse and Resolve to Work for: Laws which protect the individual's right to choose to die with dignity.

■ PRESBYTERIAN CHURCH U.S.A.

195th General Assembly (1983)

Decision-Making at the End of Life

1. Many members of the Presbyterian Church (U.S.A.) will face health care decisions toward the end of life that they could not have anticipated, and many of those decisions will require judgments that relate to values held by the patient. Therefore, the 195th General Assembly (1983) calls upon its members to:
   a) Select their physicians with regard not only to the skillfulness of the medical care that they can provide but also for their values regarding human life and community, whenever such a choice is available.
   b) Take time to reflect on their own values and discuss these with family members, close friends, and their clergy.
   c) Speak with their physicians about their concerns regarding care and become educated about their conditions in order to permit informed decision-making.
   d) Provide instructions (and designate two agents to carry out instructions) with regard to extraordinary therapies and treatments to prolong life.
2. The church should be a place where individuals and families can make plans about death, manner of death, living wills, etc. Therefore, the 195th General Assembly (1983) calls upon the church to:
   a) Request the Program Agency to make available information and study tools for use by congregations regarding options available at the end of life and means of informing health care professionals of these wishes.
   b) Hold seminars utilizing the afore-mentioned materials and qualified resource persons whenever possible.
   c) Advocate that human need and benevolence replace the opportunism and exploitation that so often surround the death experience presently.
3. Harmony and integration should be sought between intensive care, curative hospitals, and hospices so that end of life care can be free from jurisdictional conflict and that therapeutic and palliative care are available to all.

Christian Affirmation of Life

To my family, physician, lawyer and clergyperson:

...[that] I be consulted concerning the medical procedures that might be used to prolong my life as death approaches. If I can no longer take part in decisions concerning my own future, and if there is no reasonable expectation of my recovery from physical and mental disability, I request that no extraordinary means be used to prolong my life.

■ SPIRITUAL ASSEMBLY OF THE BAHA'IS OF LINCOLN, NE

As to the Baha'is viewpoint on the removal or withholding of life support in medical cases where intervention prolongs life in disabling

illness, nothing has been found in the Sacred Text specifically on this matter. In such cases decisions must be left to those responsible, including the patient.

(Written on behalf of the Universal House of Justice, May 31, 1979).

■ UNION OF AMERICAN HEBREW CONGREGATIONS

General Assembly, October, November 1991

Health Care Decisions on Dying

Jewish tradition affirms the sanctity of life, as well as the precept that every means must be undertaken to preserve life. It also affirms that when there is no hope for a patient and death is certain, impediments to death must not be created, and the patient must be allowed to die in dignity and in peace.

The Union of American Hebrew Congregations resolves to...encourage members of our congregations to use advance health care directives and/or other legally acceptable and binding writings, such as living wills and durable health care powers of attorney, as well as the words "living will" placed on all state driver's licenses, for the purpose of memorializing their respective decisions with respect to the administration of life-sustaining medical treatment and procedures in the event of their incompetency accompanied by a terminal illness or a persistent vegetative state, with no chance of recovery.... Promote and support the enactment of national, state, and provincial legislation, preferably of a uniform nature, designed to facilitate the decision making process set forth above.... Call upon all member congregations to support and join in these efforts.

■ UNITARIAN UNIVERSALISTS

The Right to Die With Dignity, 1988

Guided by our belief as Unitarian Universalists that human life has inherent dignity, which may be compromised when life is extended beyond the will or ability of a person to sustain that dignity; and believing that it is every person's inviolable right to determine in advance the course of action to be taken in the event that there is no reasonable expectation of recovery from extreme physical or mental disability; and

WHEREAS, medical knowledge and technology make possible the mechanical prolongation of life; and

WHEREAS, such prolongation may cause unnecessary suffering and/or loss of dignity while providing little or nothing of benefit to the individual; and

WHEREAS, such procedures have an impact upon a health-care system in which services are limited and are inequitably distributed; and

WHEREAS, differences exist among people over religious, moral, and legal implications of administering aid in dying when an individual of sound mind has voluntarily asked for such aid; and

WHEREAS, obstacles exist within our society against providing support for an individual's declared wish to die; and

WHEREAS, many counselors, clergy, and healthcare personnel value prolongation of life regardless of the quality of life or will to live;

THEREFORE BE IT RESOLVED: That the Unitarian Universalist Association calls upon its congregations and individual Unitarian Universalists to examine attitudes and practices in our society relative to the ending of life, as well as those in other countries and cultures; and

BE IT FURTHER RESOLVED: That Unitarian Universalists reaffirm their support for the Living Will, as declared in a 1978 resolution of the General Assembly, declare support for the Durable Power of Attorney for Health Care, and seek assurance that both instruments will be honored; and

BE IT FURTHER RESOLVED: That Unitarian Universalists advocate the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths; and

BE IT FURTHER RESOLVED: That Unitarian Universalists advocate safeguards against abuses by those who would hasten death contrary to an individual's desires; and

BE IT FINALLY RESOLVED: That Unitar-

ian Universalists, acting through their congregations, memorial societies, and appropriate organizations, inform and petition legislators to support legislation that will create legal protection for the right to die with dignity, in accordance with one's own choice.

■ UNITED CHURCH OF CHRIST

18th General Synod, July 1991, Norfolk, VA

The Rights and Responsibilities of Christians Regarding Human Death

Text of the Resolution:

WHEREAS, we live in an era of complex biomedical technologies, with various means to maintain or prolong physical life and postpone inevitable death;

WHEREAS, there are ever-increasing anxieties about a prolonged dying process with irreversible deterioration, and its potentially devastating effects on the dignity of the dying person, the emotional and physical well-being of families, as well as the responsible Christian stewardship of resources;

WHEREAS, technology advances more quickly than public policy, and public opinion is often ahead of legislative enactment;

WHEREAS, individuals have increasing responsibilities in these life and death decisions, but often lack adequate information regarding available options;

WHEREAS, life is sourced in God, and recognizing that our faith calls for commitment and work for the quality of human life with mercy, justice and truth;

WHEREAS, affirming that the gift of abundant life is more than the avoidance of death, and that over-regard for the body, without proper concern for the needs of the person or the human spirit, can become a kind of biological idolatry; we are convinced that what is required is a balanced appreciation of the whole person;

WHEREAS, we support the right and responsibility of individuals to choose their own destiny, and recognize the need for safeguards to protect persons who cannot make life and death choices for themselves.

The Eighteenth General Synod supports the rights of individuals, their designees and their families to make decisions regarding human death and dying.

...affirms the right of individuals to die with dignity and not have their lives unnecessarily prolonged by extraordinary measures if so chosen.

...calls on Christians to offer love, compassion and understanding to those who are faced with difficult life-ending decisions.

BE IT FURTHER RESOLVED, the Eighteenth General Synod encourages the enactment of legislation safeguarding these rights, including the rights of those who are unable to make decisions for themselves.

■ UNITED METHODIST CHURCH

General Conference, adopted 1972, latest revision 1988

Death With Dignity

We applaud medical science for efforts to prevent disease and illness and for advances in treatment that extend the meaningful life of human beings. At the same time, in the varying stages of death and life that advances in medical science have occasioned, we recognize the agonizing personal and moral decisions faced by the dying, their physicians, their families, and their friends. Therefore, we assert the right of every person to die with dignity, with loving personal care and without efforts to prolong terminal illnesses merely because the technology is available to do so.

Acknowledgements

Portions of this publication were adapted from:

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