ADVANCE HEALTH CARE DIRECTIVE

(*Under Authority of California Probate Code Sections 4670 et seq.*)

CATHOLIC TEACHING CONCERNING END OF LIFE DECISIONS

Death Is A Normal Part of the Human Condition. Death is neither to be feared and avoided at all costs, nor to be sought and directly procured.

Euthanasia Is Wrong. Euthanasia is not permitted. Euthanasia is defined as the intentional ending of human life by act or omission in order to relieve suffering.

Pain Relief. Modern pain control techniques do not ordinarily shorten life. However, the use of medicine to treat severe pain is acceptable even if, hypothetically, it were to shorten life. In any event, pain control is not the same as euthanasia, since death is not the objective of the treatment. Maintenance of lucidity is an important element in preparing for death, but severe pain should be alleviated to the extent possible.

Proportionality of Life-Sustaining Medical Treatment. Decisions to administer, refuse, or discontinue life-sustaining treatment should be based on the concept of proportionality. One does not have an obligation to pursue a life-sustaining treatment if its risks or burdens are disproportionate to its expected benefits. The concept of burden is broad and must be individually assessed; it includes aspects such as the discomfort, risk, and expense of the treatment in question.

Nutrition and Hydration (Food and Water). The failure to provide a patient with nutrition and hydration – *for the purpose of ending the patient's life or accelerating the patient's death* – constitutes euthanasia and is always wrong, even when nourishment must be provided by artificial means. However, situations can arise where the provision of nutrition and hydration no longer provides substantial benefits and is actually burdensome to a dying patient. In such cases, the provision of food and water, by artificial means or otherwise, may no longer be appropriate, even if the dying process is *incidentally* hastened.

Consultation with Medical and Spiritual Advisors. It is not always easy for patients, family, or health care agents to apply the principles of proportionality to a particular situation. Consultation with medical advisors is almost always required in order to evaluate potential benefits, burdens, and risks. Consultation with competent spiritual advisors may help patients, family, or health care agents arrive at objective and honest decisions.

More Detailed Guidance Is Available. Most of the foregoing principles are drawn from the *Declaration on Euthanasia* which was promulgated in 1980 by the Vatican Congregation for the Doctrine of the Faith. Additional Church documents and guidance can be found on the website of the United States Conference of Catholic Bishops: www.usccb.org/prolife.

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Part 1 – POWER OF ATTORNEY FOR HEALTH CARE

1.1 **Primary Appointment**. I,_____, hereby designate the following individual as my agent to make health care decisions for me:

Print Name: _____ Relationship: _____

Home Phone: _____ Mailing Address: _____

Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

1.2 **First Alternate Appointment**. If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Print Name: _____ Relationship: _____

Home Phone: _____ Mailing Address: _____

Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

1.3 **Second Alternate Appointment**. If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Print Name: _____ Relationship: _____

Home Phone: _____ Mailing Address: _____

Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

1.4 **Agent's Authority**. My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw medical treatment artificial nutrition and hydration and all other forms of health care to keep me alive, *except as I state in Part 2 below***.**

1.5 **When Agent's Authority Becomes Effective.** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions, unless I mark the following box: If I mark this box ☐ authority to make health care decisions for me takes effect immediately.

1.6 **Agent's Obligation**. My agent shall make health care decisions for me in accordance with (i) this power of attorney for health care, (ii) any instructions I give in Part 2 of this form, and (iii) my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.7 **Agent's Post-Death Authority**. My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Parts 3 and 4 of this form:

_____

_____

[*Continue on Page 5 if necessary*]

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1.8 **Designation of Conservator**. If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not available to act as conservator, I nominate the alternate agents I have named, in the order designated.

Part 2 – INSTRUCTIONS FOR HEALTH CARE

2.1 **Health Care Decisions Should Be Consistent With Catholic Teaching**. Any decision concerning my health care should be consistent with relevant teachings of the Roman Catholic Church. Those teachings are summarized on the first page of this Advance Health Care Directive.

End-Of-Life Decisions. It is impossible to adequately anticipate all the considerations which must be weighed at the time when a decision concerning life-sustaining treatment is to be made. Therefore, if I have appointed an agent in Part 1 above, I have full confidence in the judgment of that person, and I request that my health care providers follow his or her instructions. However, to facilitate my agents' and health care providers' decisions, I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

(a) Choice Not to Prolong Life
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, ***or*** (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, ***and*** (3) the likely risks and burdens of treatment would be disproportionate to its expected benefits. OR

(b) Choice to Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 **Relief from Pain**. Except as I state in the following spaces, I direct that treatment for alleviation of pain or discomfort be provided at all times, even it hastens my death.

_____

_____

2.3 **Special Instructions (Optional)**. The following lines may be used to set forth any further directions, limitations, or statements concerning health care, treatment, services and procedures:

_____

_____

_____

[*Continue on Page 5 if necessary*]

Part 3 – DONATION OF ORGANS (*OPTIONAL*)

The agent designated in this document has the authority to make anatomical gifts unless contrary intentions have been expressed. To clearly express your intentions, check (a) or (b) and use blank spaces for any limitations:

☐ (a) I do not wish to donate any of my organs, tissues or parts upon my death.

☐ (b) I give any needed organs, tissues, or parts,

OR – My gift is limited to the following organs, tissues or parts only:

_____

My gift is for the following purposes (cross out any of the following you do not want):

(1) Transplant (2) Therapy (3) Research (4) Education

Other limitations: _____

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Part 4 – DISPOSITION OF REMAINS (*OPTIONAL*)

4.1 **Agent's Authority**. I understand that my agent designated in this document has the authority to dispose of my remains unless I otherwise provide, in writing.

4.2 **Instructions**. My instructions for the disposition of my remains are described in:

☐ (a) A written contract for funeral services with: _____
Name of Funeral Director, Mortuary and/or Cemetery

☐ (b) My will, which I keep: _____
Location of Will

☐ (c) Instructions as follows: _____

_____
Specific Instructions

Part 5A PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

Name: _____ _____
Phone

Address: _____ _____ _____ _____
City State Zip Code

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician.

Name: _____ _____
Phone

Address: _____ _____ _____ _____
City State Zip Code

Part 5B – HIPAA DISCLOSURE AUTHORIZATION

5.1 **Authorized Disclosures of Medical Information**. I hereby grant to each of the individuals named as my primary and alternative health care agents in Part 1 of this document full power and authority to request, review and receive any information, verbal or written, regarding my physical or mental health, to the same extent that I myself would have such rights under the Health Insurance Portability and Accountability Act of 1996. I further grant to each of said individuals the further right to consent to the disclosure of such information to third parties.

5.2 **HIPAA Authorization Effective Immediately**. The foregoing authorizations are effective immediately and, notwithstanding the provisions of Section 1.5 above, are not contingent on my own inability to make health care decisions.

Part 6 – REVOCATION OF PRIOR DIRECTIVES

6.1 **Revocation of Prior Appointments of Health Care Agents**. By execution of this document, I hereby revoke all prior Powers of Attorney for Health Care and any and all other appointments of health care agents under the laws of any jurisdiction within or without the United States of America.

6.2 **Revocation of Prior Health Care Directives**. By execution of this document, I hereby revoke all prior documents, wherever executed within or without the United States of America, which would be deemed to function as an Advance Health Care Directive under the laws of the State of California.

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Part 7 – SIGNATURE AND WITNESSES

7.1 **Effect of Copy**. A copy of this form has the same effect as the original.

7.2 **Signature and Date**.

Date of Signature:_____, 20_____ _____
(*sign your name*)

Place of Signature: _____

7.3 **Statement of Witnesses**. I declare under penalty of perjury under the laws of California (i) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (ii) that the individual signed or acknowledged this advance directive in my presence, (iii) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (iv) that I am not a person appointed as agent by this advance directive, and (v) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness: _____ Address: _____
(signature)

_____ _____ _____
(*date*) (*printed name*)

Second Witness: _____ Address: _____
(*signature*)

_____ _____ _____
(*date*) (*printed name*)

7.4 **Additional Witness Statement**. At least one of the above witnesses must also sign a declaration as follows:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____ _____
(*signature*) (*signature*)

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Part 8 – ACKNOWLEDGMENT BEFORE NOTARY PUBLIC

8.1 **Notary Public Acknowledgment As Alternative To Witnesses In Part 7**. Acknowledgment before a Notary Public is not required if properly witnessed in Part 7 above. Acknowledgment before a Notary Public does not eliminate the need for the Statement of a Patient Advocate or Ombudsman, in Part 9 below, which is required for patients in skilled nursing facilities.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA)
) ss
COUNTY OF LOS ANGELES)

On_____, 20_____, before me,_____,
personally appeared_____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under the PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

_____

Notary Public [*Seal*]

Part 9 – SPECIAL WITNESS REQUIREMENT (*FOR PATIENTS IN SKILLED NURSING FACILITIES*)

9.1 **Patient Advocate or Ombudsman**. The following statement is required only for patients in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. In such situations, the patient advocate or ombudsman must sign the following statement, even if this document is notarized.

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STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Date: _____, 20____ _____ Address: _____

(*signature*)

_____ _____

(*printed name*)

SPACE FOR ADDITIONAL LIMITATIONS AND/OR INSTRUCTIONS

[*Sections 1.7 and 2.3*]

COPIES

CALIFORNIA LAW PERMITS PHOTOCOPIES OF THIS DOCUMENT TO BE RELIED UPON AS THOUGH THEY WERE ORIGINALS. IT IS RECOMMENDED THAT YOU KEEP POSSESSION OF YOUR ORIGINAL AND THAT YOU CONSIDER GIVING PHOTOCOPIES TO – AND DISCUSS YOUR SPECIFIC DESIRES WITH:

(1) YOUR AGENT AND ALTERNATIVE AGENTS,
(2) YOUR PRIMARY PHYSICIAN,
(3) SIGNIFICANT MEMBERS OF YOUR FAMILY, AND
(4) ANY OTHER PERSON WHO IS LIKELY TO BE CALLED IN A MEDICAL EMERGENCY.

IT IS VERY IMPORTANT TO KEEP A RECORD OF THE PERSONS WHO HAVE RECEIVED COPIES – IN CASE YOU WISH TO REVOKE OR MODIFY THIS DIRECTIVE.

CHECKLIST FOR ADVANCE HEALTH CARE DIRECTIVE

TO ENSURE THAT YOU HAVE COMPLETED THIS FORM PROPERLY, YOU SHOULD BE ABLE TO ANSWER "YES" TO EACH OF THE FOLLOWING ITEMS:

☐ 1. I am a California resident who is at least 18 years old, of sound mind and acting of my own free will.

☐ 2. The individual I have selected to make health care decisions for me (my "Agent" or "Alternative Agent") is at least 18 years of age and, at the time when such Agent will be making health care decisions on my behalf, is not and will not be:

- a supervising health care provider or an employee of the health care institution where I am then receiving care,
- an operator of a community care facility or residential care facility where I am then receiving care,
- an employee of a health care facility, community care facility or residential care facility for the elderly where I am then receiving care, unless such employee is related to me by blood, marriage or adoption, or unless I am also employed by the same health care institution, community care facility or residential facility for the elderly, and
- my conservator under the Lanterman-Petris-Short Act, unless additional legal requirements have been met.

☐ 3. I have spoken with the individuals I have selected to make health care decisions on my behalf, and these individuals have agreed to do so in the event I am unable to make such decisions for myself.

☐ 4. We have discussed the extent to which life-sustaining treatment (for example, ventilators/respirators, dialysis, chemotherapy, surgery, tube-feeding, CPR) should be implemented or maintained on my behalf.

☐ 5. The individuals I have selected understand how I would act on my behalf were I able to do so.

☐ 6. I have given a copy of this completed form to those who may need it in case an emergency requires a decision concerning my health care, including the individuals I have selected in this form, key family members and physicians.

☐ 7. I have had this form either notarized OR properly witnessed.

☐ a. I have obtained the signatures of two adult witnesses who personally know me (or to whom I have proven my identity).

☐ b. Neither witness is

- an Agent whom I have designated to make health care decisions of my behalf,
- one of my health care providers or any employee of one of my health care providers,
- the operator or any employee of a community care facility (sometimes called a "board and care home"), nor
- the operator or any employee of a residential care facility for the elderly.

☐ c. At least one witness is not related to me by blood, marriage or adoption, and is not named in my will and, so far as I know, is not entitled to any part of my estate when I die.

☐ 8. I understand that, if I want to change anything in this document, I must complete a new form. I should also tell everyone who received a copy of the old form that it is no longer valid and must ask that copies of the old form be returned to me so that I may destroy them.

☐ 9. I have signed and dated this form.

☐ 10. I understand that an informative brochure is available that explains this form and relevant Catholic principles in greater depth.

☐ 11. If I am in a skilled nursing facility, I have obtained the signature of a patient advocate or ombudsman.

☐ 12. If I am a Conservatee under the Lanterman-Petris-Short Act, this form may not be applicable and I should consult an attorney.

☐ 13. I am keeping a record of the persons who have received copies of this Advance Health Care Directive.