



ADVANCED HEALTH CARE DIRECTIVE

As a service to those living in the Archdiocese of Los Angeles, we have posted a form of an Advanced Health Care Directive on our website. You can print the Directive out, discuss it with your family members and, if you wish, complete and sign the Directive so that the persons you designate will have full authority to carry out your wishes should there be a time when you are unable to make medical decisions for yourself.

As you consider how you and your family wish to address these end of life and health issues, the teaching of the Roman Catholic Church on these matters is clearly stated in the following two paragraphs from the Catechism of the Catholic Church:

Paragraph 2278: *Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of “over-zealous” treatment. Here one does not will to cause death; one’s inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.*

Paragraph 2279: *Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.*

The form of Advanced Health Care Directive posted on the Archdiocesan website, includes detailed choices and directions. It is currently available in English and will be made available soon in Spanish, with both forms updated to address recent changes in the privacy aspects of Federal Health Insurance Portability and Accountability Act (HIPAA). The California Medical Association also currently provides an English and Spanish form of advanced health care directive at its website www.cmanet.org for a fee.

ADVANCE HEALTH CARE DIRECTIVE

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

WARNING: THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding organ donations and the disposition of your remains. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as an agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, medication, or procedure to diagnose, alleviate, or otherwise affect a physical or mental condition.
- (b) Select or discharge health care providers and institutions.

- (c) Direct the provision, withholding, or withdrawal of medically assisted nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (d) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent.

Section 2.1 contains a brief summary of relevant Catholic teaching concerning the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to provide additional instructions to your agent. You should understand that the assisted intake of food and water (sometimes termed "nutrition and hydration") is often regarded as "medical treatment" unless you or your agent specify otherwise. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Section 2.3 of this form.

Part 3 is optional. It allows you to express your intentions to concerning gifts of your bodily organs and tissues following your death.

Part 4 is also optional. It allows you to direct the disposition of your remains.

After completing this form, sign and date it on Page 3.

The form must also be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the completed and signed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named.

You have the right to revoke this advance health care directive or replace this form at any time. Your revocation may be accomplished in any manner that communicates your intention. See Probate Code §4695 and §4696.

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: _____

Mailing Address: _____

Home Phone: _____

Work Phone: _____

SS# (optional, for identification): _____

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: _____ Mailing Address: _____
Home Phone: _____
Work Phone: _____ SS# (optional, for identification): _____
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: _____ Mailing Address: _____
Home Phone: _____
Work Phone: _____ SS# (optional, for identification): _____
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 medically assisted nutrition and hydration (food and water)* 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 sign my name to the following authorization:

Immediate Authorization (Optional): My agent's authority to make health care decisions for me takes effect immediately, even though I am currently competent to make my own health care decisions. I reserve the right to revoke this authority or to object to any decision by my agent at any time.

Optional Signature: _____

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]

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 extensively discussed in the Declaration on Euthanasia which was promulgated in 1980 by the Vatican Congregation for the Doctrine of the Faith and which may be summarized as follows:

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|--|
| <ul style="list-style-type: none">(a) Death is neither to be feared and avoided at all costs, nor to be sought and directly procured.(b) Euthanasia is not permitted. Euthanasia is defined as the intentional ending of human life by act or omission in order to relieve suffering. |
|--|

- (c) Modern pain control techniques do not, in fact, 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.
- (d) It is not always necessary to use all life-sustaining treatments. One does not have an obligation to pursue a treatment if its risks or burdens are disproportionate to its expected results or benefits. The concept of burden is broad and must be individually assessed; it includes aspects such as pain, expense, risk, and inconvenience of the treatment as perceived by the person being treated.

2.2 **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.

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 [e.g. provision of food and fluids (nutrition and hydration)]:

[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. In order 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: _____

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 5 - SIGNATURE AND WITNESSES

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

5.2 **Signature and Date.**

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

Place of Signature: _____

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.