

ADVANCE MEDICAL DIRECTIVE (LIVING WILL) AND HEALTH CARE
POWER-OF-ATTORNEY AUTHORISATION

This Declaration on My Life is made by me (full name of the person)

.....

(Date of Birth.....; ID Document and Number.....)

resident of (full address)

.....

on (date).....at place

I am an adult, of sound mind and am making this 'declaration' of my own free will, ie voluntarily and after careful consideration. If the time comes that I can no longer take part in decision making regarding my medical treatment, this 'declaration' will comprise the final expression of my wishes. It is requested that all concerned should take these wishes into account before taking any medical decision regarding my life. If at any time, I

1. Reach the stage of terminal illness and go into a coma with no reasonable expectation of regaining consciousness, or
2. Have a disease state from which I have no reasonable expectation of recovering with acceptable quality of life
3. Reach a persistent vegetative stage with no reasonable expectation of regaining significant cognitive functioning

then the following steps must be taken. I request that a panel of three doctors of appropriate expertise and experience should be constituted by the administrative head of the hospital where I am admitted for treatment. Their views should then be sought on the above. If any/all of the three situations above are confirmed then I should be deemed to have declined to receive the following life sustaining treatments as listed below. Any of these measures already started, should be removed.

1. Intravenous fluids and medications including antibiotics
2. Artificial feeding by nasogastric tube or gastrostomy
3. Dialysis
4. Artificial respiration
5. Chemotherapy
6. Cardio-pulmonary resuscitation

Other wishes: (please write by hand)

I request that this 'declaration' should be honoured by my family members and physicians as the final expression of my legal right to refuse medical or surgical treatment accepting the consequences of such refusal. This document may be informed to my regular physician.....

To secure compliance with this declaration, to make medical decisions as may be required from time to time on my behalf, I hereby appoint the following as my Surrogate decision maker/s or Health Care Power-of-Attorney. S/he/they have expressed acceptance of this responsibility. I hereby vest in my attorney the power to obtain medical information, make decisions and take action on my behalf with regard to wishes expressed in this 'declaration', notwithstanding any contrary views held by any other person.

1. NameSignature.....
(Date of Birth.....; ID document and number.....
Phone.....Email.....)Resident
of If this
person is not available, the next two persons may be approached in the
same order
2. Name (Date of
Birth.....; ID document and number.....
Phone.....Email.....)Resident
of
3. Name (Date of
Birth.....; ID document and number.....
Phone.....Email.....)Resident
of

In the absence of any of these authorized attorneys any member of my family will have the authority to express the wishes on my behalf regarding the above treatment.

I declare that this 'Declaration' and 'Attorney Authorization' shall remain in force during my life time unless I revoke it at any time and until notice of its revocation has been received by my attorneys.

I understand full importance of this 'Declaration' and 'Attorney Authorization' and am fully competent to make it.

SIGNATURE

DATE.....

PLACE.....

WITNESSES:

This 'Declaration' and 'Attorney Authorization' has been signed in the presence of undersigned by (Name of Declarant) who is known to me and I believe that the signatory is of sound mind.

Witness I.

Name.....

Signature

Address

Witness II.

Name.....

Signature

Address

SIGNED BEFORE ME

APPROPRIATE AUTHORITY, STAMP

What is a Living Will?

It is important for people to plan their future healthcare, especially at a time when they may no longer be able to make decisions or communicate these decisions. The "Living Will" will provide people the opportunity to think about, talk about and write down their wishes, preferences, priorities and refusals. They can make their own decisions on how they would like to be cared for and what they prefer to have and have not towards the end of their life. They may find it helpful to talk to their family and friends about their future care. Although families and loved ones may become emotional or disagree with their decisions, talking about these things openly can often be very helpful for the future. It will help all concerned to understand what is important for the person making the decision and to know the views, wishes and preferences of the person about the array of treatment options offered by the health care professionals at end of life. It will help them to be clear about the decisions they make. The "Living Will" is a written record of person's wishes that will help the nominated person(s) or your family to carry out person's wishes at the appropriate time without any guilt or angst.

Preferred priorities can be stated. This means those things they wish or prefer to have towards the end of life. It involves aspects like their preferred place of care and death (home or hospital), nature of treatment they would like to receive, information about their health and illness they would like to know and the supports they would like to access at end of life.

It is preferable to be clear about binding refusals. This means those components of medical care they wish or prefer not to have towards their end of life. It involves avoidance of IV fluids, antibiotics, blood products, hospitalisation, intensive care admission, oxygen, dialysis, feeding tubes, artificial nutrition etc. It also involves confirming a preference of not to have invasive medical procedures aimed at resuscitation like chest compressions, mechanical ventilation, drugs to increase blood pressure, invasive tubes, artificial machines aimed at keeping a person alive at the end of their life. Although these are termed binding refusals, in certain situations the Surrogate (the person who has been given Health Care Power of Attorney) can override them based on medical advice, if it is thought that the situation may significantly improve with a short period of the above treatments.

Can the person making this decision cancel his/her decision or change the preferred priorities and binding refusals?

Yes, the person making the Living Will can cancel their decision and discard this form any time. They can also change your preferred priorities and binding refusals at any time. They can also redo the form again and change the nominated persons. To ensure that everyone has the current version of the "Living Will" they are advised to destroy the earlier versions and keep a copy of the current version with them and share the current version with their general practitioner and with their hospital physician and hospital medical records.

What is nominating a Surrogate or Health Care Power of Attorney?

Medicine is an inexact and rapidly changing science. Not all situations can be foreseen. Some treatments that may have a binding refusal in the living will may be required for a short period and there may be a good chance of recovery. These situations require doctors and health care professionals to interact with someone who can represent the patient for shared decision making. This person is the Surrogate (also termed Health Care Power of Attorney). The Living Will allows the patient to appoint in advance some person(s) to make healthcare decisions if and when s/he is unable to make these decisions. The Living Will gives the Surrogate the authority to make decisions on behalf of the person only when the person has been determined unable to make their own decisions by the health care providers. It *does not* give authority to the Surrogate to make financial or other business decisions. It is very important for the person making the Living Will to discuss their views, values, and the provisions of this document with their Surrogate. It is important for the Surrogate to understand person's wishes, preferences and the refusals stated in the document, accept and agree with the plan and willing to execute it at the appointed time. Preferably the consenting Surrogate should also sign on the Living Will form or the patient must confirm on the form that the Surrogate has accepted this responsibility.

What are my role and responsibilities as a Surrogate (Health Care Power of Attorney)?

This appointment shall become effective only when the person making the Living Will is unable to participate in the health treatment decisions. You will act on behalf of the person making the Living Will

and advocate for person's wishes, preferences and refusals stated in the document. You may have to advocate on behalf of the person with the person's family, health care provider and hospital administration. You have to agree and accept the role of the Surrogate and if possible demonstrate your acceptance by signing the Living Will form.

You will not exercise powers concerning the person's finances or businesses, family custody, legal transactions, property, employment etc. You cannot receive payment for serving as a Patient Advocate and will not be reimbursed for expenses which you may incur in fulfilling your role and responsibilities as a Patient Advocate. The person making his Living Will has every right to revoke your appointment and appoint others. You cannot override the decision of the healthcare provider if he/she feels that you are not acting in the best interests of the patient or the wishes and preferences stated in the Living Will are not applicable to the current health situation.

When will the Living Will come into effect?

The "Living Will" will come into effect only when the person making the Living Will is unable to make or communicate a decision for themselves. At this time the health care provider will refer to the wishes, preferences and the refusals stated in the document and will consult the person nominated by the person or their family before carrying out the wishes. The healthcare provider will be guided by the person's best interests and if the healthcare provider finds that provisions of the living will or the opinion of the nominated person or family is not consistent with the health care situation, the healthcare provider has the right to disregard the Living Will. The overarching purpose of the Living Will is to provide a humane, comfortable and dignified end of life and avoid potentially inappropriate treatment against the patient's wishes.

Guidance for Completing the Living Will Form

Please read the complete document before completing the Living Will Form.

Providing your personal details

- You are requested to state your name in full. Both Given Names and Surname (Family Name) has to be provided
- Please provide one of the document mentioned in the list of documents accepted as the proof of identity and address by the Government of India. Please mention the name of the document and the identification number/alphanumerical stated in the document.
Please access the link provided to know the list of documents accepted as proof of identity.
http://www.dot.gov.in/sites/default/files/2016_11_18%20POIA-AS-II.pdf?download=1
- Please provide your present residential address or address for communication
- Please provide your telephone and email address(optional).
- If there are any preferences and refusals not covered in the living will, please write those in the space provided (Other Wishes: write by hand).
- If you would like to cancel the document, please cross the entire document and write cancelled and sign. Please inform your nominated person, family, general practitioner and health care provider about cancellation of the document.

Nominating someone to make decision for you (Appointing the Surrogate or Health Care Power of Attorney)

- Please indicate the name of the Surrogate with whom you have discussed your living will
- Please ask the Surrogate to read the complete document before completing this section
- The Surrogate has to accept this responsibility preferably by signing the document.
- Health care providers cannot be surrogates unless they are related to the patient.

Sharing information about your Living Will

- Please indicate the name of your general practitioner/hospital physician/hospital and consent for this document to be shared.

Declaration, Witnessing and Attestation

- Please read all the declaration statements carefully and sign and date the declaration
- The document should be witnessed by two persons who are not the surrogate, family member or your healthcare provider.
- The document will have to be signed in the presence of the concerned authority as may be specified (currently Judicial Magistrate First Class) who will then attest it.

Assistance with completing the Living Will

- If you are unable to read or write, then a person who is not the patient advocate, family member or your healthcare provider, can read you out the Living Will information and contents of this form and assist you in completing this form. The person assisting you with this form has to provide their details.

ONLINE LIVING WILL AND ADVANCE MEDICAL DIRECTIVE RESOURCES

Many online resources are available, mainly from the USA. The following section is a short list of the options currently available. Downloadable forms may allow individuals to make more detailed Living Wills than the sample form given above. Currently there is no officially prescribed form for Indian citizens and

1. Five Wishes: <https://fivewishes.org/Home>
2. USA States Official Living Wills: these are available at more than one site
 - a. <https://www.uslegalforms.com/findlaw/livingwills/>
 - b. <http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289>
 - c. <https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/>
3. Making Your Wishes Known: < <https://www.makingyourwishesknown.com/default.aspx>>
4. Emanuel Medical Centre: < https://www.emmanuelmedicalcenter.org/docs/librariesprovider63/default-document-library/advance-care-planning-rev-16-06.pdf?sfvrsn=3116423e_0>
5. Gift Of Peace of Mind: <https://www.amerhealthcaritasia.com/pdf/provider/forms/advance-directive.pdf>